

MONTANA LEGISLATIVE HISTORY

Chapter 416 1997

Bill H \_\_\_\_\_ S 378

Original bill & history ☒ C

H. Committee on Human Services S. Committee on Bus. Industry

Hearing Date(s) \_\_\_\_\_ C

3/14 ☒ C

\_\_\_\_\_ C

\_\_\_\_\_ C

Date Out 3/27 ☒ C

Hearing Date(s) \_\_\_\_\_ C

2/20 ☒ C

\_\_\_\_\_ C

\_\_\_\_\_ C

2/21 ☒ C

Did this bill originate in an interim committee? ☐ Yes ☐ No

Committee \_\_\_\_\_

Report \_\_\_\_\_

|                                                      |                                            |    |   |
|------------------------------------------------------|--------------------------------------------|----|---|
| TRANSMITTED TO HOUSE                                 |                                            |    |   |
| 3/03                                                 | FIRST READING                              |    |   |
| 3/03                                                 | REFERRED TO NATURAL RESOURCES              |    |   |
| 3/10                                                 | HEARING                                    |    |   |
| 4/03                                                 | COMMITTEE REPORT—BILL CONCURRED AS AMENDED |    |   |
| 4/08                                                 | 2ND READING CONCURRED AS AMENDED           | 96 | 4 |
| 4/08                                                 | REVISED FISCAL NOTE REQUESTED              |    |   |
| 4/09                                                 | 3RD READING CONCURRED                      | 95 | 5 |
| RETURNED TO SENATE WITH AMENDMENTS                   |                                            |    |   |
| 4/12                                                 | REVISED FISCAL NOTE RECEIVED               |    |   |
| 4/14                                                 | REVISED FISCAL NOTE PRINTED                |    |   |
| 4/15                                                 | 2ND READING AMENDMENTS CONCURRED           | 49 | 0 |
| 4/16                                                 | 3RD READING CONCURRED AS AMENDED           | 49 | 1 |
| 4/21                                                 | SIGNED BY PRESIDENT                        |    |   |
| 4/21                                                 | SIGNED BY SPEAKER                          |    |   |
| 4/21                                                 | TRANSMITTED TO GOVERNOR                    |    |   |
| 4/28                                                 | SIGNED BY GOVERNOR                         |    |   |
| CHAPTER NUMBER 415                                   |                                            |    |   |
| EFFECTIVE DATE: 04/28/97—SECTIONS 5 & 29             |                                            |    |   |
| EFFECTIVE DATE: 07/01/97—SECTIONS 1, 2, 4, 6-28 & 30 |                                            |    |   |
| EFFECTIVE DATE: 07/01/99—SECTION 3                   |                                            |    |   |

SB 378 INTRODUCED BY BENEDICT, ET AL.

LC0332 DRAFTER: NISS

## REVISE INSURANCE LAWS

|                                                         |                                            |    |    |
|---------------------------------------------------------|--------------------------------------------|----|----|
| 2/17                                                    | INTRODUCED                                 |    |    |
| 2/17                                                    | FIRST READING                              |    |    |
| 2/17                                                    | REFERRED TO BUSINESS & INDUSTRY            |    |    |
| 2/17                                                    | FISCAL NOTE REQUESTED                      |    |    |
| 2/19                                                    | FISCAL NOTE RECEIVED                       |    |    |
| 2/20                                                    | HEARING                                    |    |    |
| 2/20                                                    | FISCAL NOTE PRINTED                        |    |    |
| 2/21                                                    | COMMITTEE REPORT—BILL PASSED AS AMENDED    |    |    |
| 2/25                                                    | 2ND READING PASSED AS AMENDED              | 50 | 0  |
| 2/26                                                    | 3RD READING PASSED                         | 47 | 2  |
| TRANSMITTED TO HOUSE                                    |                                            |    |    |
| 3/03                                                    | FIRST READING                              |    |    |
| 3/03                                                    | REFERRED TO HUMAN SERVICES & AGING         |    |    |
| 3/12                                                    | REVISED FISCAL NOTE RECEIVED               |    |    |
| 3/13                                                    | REVISED FISCAL NOTE PRINTED                |    |    |
| 3/14                                                    | HEARING                                    |    |    |
| 4/03                                                    | COMMITTEE REPORT—BILL CONCURRED AS AMENDED |    |    |
| 4/05                                                    | 2ND READING CONCURRED                      | 87 | 13 |
| 4/07                                                    | 3RD READING CONCURRED                      | 82 | 18 |
| RETURNED TO SENATE WITH AMENDMENTS                      |                                            |    |    |
| 4/11                                                    | 2ND READING AMENDMENTS CONCURRED           | 50 | 0  |
| 4/12                                                    | 3RD READING CONCURRED AS AMENDED           | 47 | 1  |
| 4/18                                                    | SIGNED BY PRESIDENT                        |    |    |
| 4/20                                                    | SIGNED BY SPEAKER                          |    |    |
| 4/21                                                    | TRANSMITTED TO GOVERNOR                    |    |    |
| 4/28                                                    | SIGNED BY GOVERNOR                         |    |    |
| CHAPTER NUMBER 416                                      |                                            |    |    |
| EFFECTIVE DATE: 04/28/97—SECTIONS 45 & 53               |                                            |    |    |
| EFFECTIVE DATE: 07/01/97—SECTIONS 1, 5-8, 17-40 & 42-44 |                                            |    |    |
| EFFECTIVE DATE: 09/01/97—SECTION 41                     |                                            |    |    |
| EFFECTIVE DATE: 10/01/97—SECTIONS 2-4, 10-16 & 46-52    |                                            |    |    |
| EFFECTIVE DATE: 01/01/98—SECTION 9                      |                                            |    |    |

### LEGISLATIVE HISTORIES

The 1997 Montana Legislature dramatically changed the nature of legislative minutes. This altered format continues with the 1999 legislative minutes. The minutes from House committees are extremely sparse in content, offering no substantive information from which to glean legislative intent. The Senate committees' minutes are fuller in content.

Exhibits, which include written statements, attendant information, roll call votes, roll call attendance, a list of those from the public who were present, and specific action taken on legislative bills, will be available only through the Historical Society Archives, 444-4774, and from a CD-ROM produced by the Legislative Services Division, 444-3064.

Just as in the 1997 legislative session, the 1999 House and Senate committee hearings were recorded. For information on accessing the tapes, or purchasing them, contact the Archives, 444-4774.

If you have concerns over the format of these legislative minutes, it is suggested that you contact your state legislators.

This bill is 75 pages long. A full copy will be provided upon request.

Senate BILL NO. 378

INTRODUCED BY

*Benedict*  
*Foster*

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING INSURANCE LAWS; REVISING INSURANCE LAWS TO COMPLY WITH PUBLIC LAW 104-191; PROHIBITING THE USE OF PREEXISTING CONDITION EXCLUSIONS AS THOSE EXCLUSIONS APPLY TO CERTAIN ELIGIBLE INDIVIDUALS; REGULATING LONG-TERM CARE INSURANCE CONTRACTS; REVISING THE MONTANA COMPREHENSIVE HEALTH CARE ASSOCIATION PLAN TO PROVIDE FOR AN ASSOCIATION PORTABILITY PLAN TO COMPLY WITH PUBLIC LAW 104-191; REVISING THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT; PROVIDING FOR GUARANTEED RENEWABILITY OF INDIVIDUAL AND GROUP HEALTH INSURANCE COVERAGE; ENACTING THE VIATICAL SETTLEMENT ACT; PROVIDING FOR LICENSURE OF VIATICAL SETTLEMENT BROKERS; REGULATING VIATICAL SETTLEMENT CONTRACTS; AUTHORIZING THE COMMISSIONER OF INSURANCE TO ADOPT RULES; REQUIRING COVERAGE FOR A MINIMUM HOSPITAL STAY FOLLOWING CHILDBIRTH; AMENDING SECTIONS 33-15-403, 33-20-128, 33-22-101, 33-22-109, 33-22-110, 33-22-130, 33-22-242, 33-22-504, 33-22-703, 33-22-1107, 33-22-1108, 33-22-1111, 33-22-1113, 33-22-1114, 33-22-1115, 33-22-1121, 33-22-1501, 33-22-1512, 33-22-1513, 33-22-1516, 33-22-1803, 33-22-1804, 33-22-1809, 33-22-1811, 33-22-1819, 33-22-1827, 33-22-1828, 33-30-1001, 33-31-102, 33-31-111, 33-31-301, 33-31-322, AND 33-35-306, MCA; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE."

#### STATEMENT OF INTENT

A statement of intent is required for this bill because [sections 46 and 61] authorize or require rules to be adopted by the commissioner of insurance to implement various sections of [this act].

It is the intent of the legislature that rules adopted pursuant to [section 46] not extend the existing control and regulatory authority of the state auditor beyond that necessary to implement Public Law 104-191.

The rulemaking authority provided in [section 61] is consistent with the requirements of Public Law 104-191, which provides for the adoption of standards promulgated by the national association of insurance commissioners. In adopting rules, the commissioner is to establish trade practice standards for regulating advertising and solicitation of viatical settlement contracts, for evaluating reasonableness of

MINUTES

MONTANA SENATE  
55th LEGISLATURE - REGULAR SESSION  
COMMITTEE ON BUSINESS & INDUSTRY

Call to Order: By CHAIRMAN JOHN HERTEL, on February 20, 1997, at  
8:00 A.M., in ROOM 410.

ROLL CALL

Members Present:

Sen. John R. Hertel, Chairman (R)  
Sen. Steve Benedict, Vice Chairman (R)  
Sen. Debbie Bowman Shea (D)  
Sen. William S. Crismore (R)  
Sen. C.A. Casey Emerson (R)  
Sen. Bea McCarthy (D)

Members Excused: None

Members Absent: None

Staff Present: Bart Campbell, Legislative Services Division  
Mary Gay Wells, Committee Secretary

Please Note: These are summary minutes. Testimony and  
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: SB 376; SB 378; 2/17/97  
SB 381; 2/18/97  
Executive Action: SB 343; HB 131;  
SB 347 TABLED

{Tape: 1; Side: A; Approx. Time Count: 8:06 AM; Comments: N/A.}

EXECUTIVE ACTION ON SB 343

Motion: SEN. DEBBIE SHEA MOVED DO PASS SB 343.

Amendments: SEN. CASEY EMERSON MOVED to Amend SB 343 (EXHIBIT 1)  
sb034303.abc.

Discussion: Ms. Mona Jamison, American Automobile Manufacturing  
Assoc. was asked to explain the amendment. Mr. Tom Harrison,  
Helena Attorney for car dealers, was also asked to give his view  
of the amendment. (The same four amendments that are being  
presented were spoken on at great length yesterday 1/19/97.)

into effect, right? Mr. Campbell said yes they could change that rule right now.

Vote : The motion to AMEND SB 347 CARRIED with SENATORS HERTEL and CRISMORE voting NO: 3-2. SEN. BENEDICT was absent.

Motion/Vote: SEN. BEA MCCARTHY MOVED TO TABLE SB 347. The motion TO TABLE CARRIED UNANIMOUSLY: 5-0.

SEN. CASEY EMERSON asked to pass a resolution that the committee direct CHAIRMAN JOHN HERTEL write a letter to the Commerce Department so that they will incorporate the device that will allow the elevator(s) to stop at the first available floor and discharge the patrons. CHAIRMAN HERTEL agreed to write this letter.

{Tape: 1; Side: B; Approx. Time Count: 8:53 AM; Comments: ONE SENTENCE WAS LOST IN THE TURN. .}

{Tape: 1; Side: B; Approx. Time Count: 9:06 AM; Comments: A 13 MINUTE BREAK WAS TAKEN.}

#### HEARING ON SB 378

Sponsor: SENATOR STEVE BENEDICT, SD 30, HAMILTON

Proponents: Tom Hopgood, Health Insurance Assoc. of America  
Kate Cholewa, MT Women's Lobby  
Claudia Clifford, Auditor's Office  
Laurie Ekanger, Governor's Office  
Jim Malgram, MT Independent Living Program  
Al Smith, Montana Advocacy Program  
Bill Jensen, Blue Cross and Blue Shield of MT and  
Chairman, Montana Comprehensive Health  
Association  
Jim Mitchell, Director, Student Health Service,  
MSU, Bozeman  
Ed Grogan, Montana Medical Benefit Plan

Opponents: None

#### Opening Statement by Sponsor:

SENATOR STEVE BENEDICT, SD 30, HAMILTON. I bring to you today SB 378. I would like to give you a bit of history. Insurance has been regulated historically at the state level. With the increased popularity of self-funded health plans, the federal government through the Employment, Retirement, Income Security Act more commonly known as ERISA, has preempted state regulation of many larger health plans. Now, for the first time, the federal government is inserting itself into the state process and the standards for which individual states have adopted will now apply to these self-funded plans as well. SB 378 brings Montana law into compliance with the federal Health Insurance Portability and Accountability Act commonly known as K-K or

Kennedy-Kassebaum. The federal law imposes a uniform set of regulations on health benefits both insured and self-funded and this bill will allow Montana to regulate the insurance industry providing health benefits to Montana consumers. I want to make sure that Montana consumers are protected by Montana laws. Enforcement should be local and not out of Washington, D.C. That is the reason for this bill. If we don't adopt a bill like this, we are going to put ourselves at the mercy of the federal government. That is not in the best interest of the State of Montana.

The bill falls into five main parts: Protections in the health and insurance industry; Long term care benefits; Viatical settlement regulation; Mental health expansion; and Minimum hospital stays following childbirth.

The health insurance protections are the area that are the most complex. I will divide that into a number of subsections. Amendment of current law or pre-existing waiting periods; credit for qualifying previous coverage; small group reform expansion; anti-discrimination of the large group market; guaranteed renewal non-cancellation in the large group market; and state opt-out provisions for federally qualified individuals.

Pre-existing waiting periods: except for certain limited disability policies such as disability income, pre-existing condition waiting periods have been redefined. For individual coverage, a pre-existing condition is one for which medical advice or treatment has been given within the last three years. The condition can only be excluded for up to 12 months. For group coverage, a pre-existing condition is one for which medical advice or treatment was provided within the previous six-month period and can only be excluded for up to 12 months. So we have the 12 month forward looking and the 6 month look back periods. As is already the case, under the Montana law, there are not pre-existing waiting periods for newborns continuously covered or for adopted children continuously covered.

Credit for qualifying previous coverage: individuals who have been covered under health plans, insured and self-insured groups and insured individuals, are given credit for having met a pre-existing waiting period if they remain continuously covered and have less than a 63 day break in their coverage.

The small group reform expansion includes guaranteed issue of health benefits regardless of health status or claims experience; guaranteed renewal of coverage, credit for pre-existing waiting periods of continually covered; and some waiting restrictions. The law will be amended to include employer groups between 2 and 50 employees.

Anti-discrimination in the large market group, the MEWAS, the large group insured coverage which is 51 plus employees and MEWAS, these are Multiple Employer Welfare Arrangements. This

particular committee does not deal often with these types of laws so I will try to explain as much as possible as I go through the bill. These two groups cannot discriminate against an individual because of health status or claims history. This is a provision which has been in place for the small group market as a result of previous Montana law.

Guaranteed renewal and non-cancellation in the large group markets and MEWAS: The guaranteed renewal provision which went into place for small group coverage with the Small Employer Health Insurance Availability Act and the Individual Guaranteed Renewal Non-cancellation passed in the last session are extended to large and shared group coverage and MEWAS as well.

State opt-out provisions for federally qualified individuals: This provision was perhaps the most talked about but least understood provision of the federal act. Combined with predator qualifying previous coverage, continuity of coverage discussed already, the federal law provides the individuals who have been previously covered by any health benefit plan or self-insured can continue some form of coverage without meeting another waiting period. If the individual goes to work for another employer providing health benefits, the individual is to be immediately covered. If an individual leaves a group health plan situation, they can apply for individual coverage. If they are accepted by the individual insurer according to the insurer's underwriting criteria, the person is given credit for pre-existing waiting periods met. If the individual cannot get individual health insurance because of medical conditions or claims experience, the state can provide another method of insurance. This is the state opt-out provision. The provision that I am recommending is the use of the Montana Conference Health Association, which is our high risk pool. It is a good example where Montana was ahead of its time in providing access to health benefits for Montanans who otherwise could not be covered. Federal law allows this mechanism to be used in meeting federal requirements.

Long term care amendments that qualify long term insurance contracts which receive favorable tax treatment by the IRS are added to Montana insurance law. The benefit triggers will be established by rule but will require the mandatory provision of long term care benefits when a covered individual meets certain requirements. These would be established by rule. Several provisions of existing law were amended as well to bring them into compliance for long term care benefits paid to a life insurance policy. Quarterly reporting requirements are changed to monthly.

Viatical settlements: I won't go into that because we did hear a viatical settlement bill and SEN. MCCARTHY now knows how to pronounce viatical.

Mental health expansion and mental health benefits are expanded for groups with more than 50 employees who offer mental health



coverage. In Montana's mandate, this is all large insured groups.

The coverage aggregates may not be more restrictive than for (?) health generally. This expansion is effective until September 30, 2001 and does not apply if the increased cost of coverage is more than 1%. Health insurance policies regulated by the State must provide for a minimum in-patient hospital stay following childbirth. This is basically the intent of the bill. The bill has been worked on by a lot of people in the industry. I would commend the Insurance Commissioner's office for their availability and expertise. This at least gives us the basic framework.

*{Tape: 1; Side: B; Approx. Time Count: 9:17 AM; Comments: N/A.}*

Proponents' Testimony:

Tom Hopgood, Health Insurance Association of America. SEN. BENEDICT stated that this is a bill that has had a lot of work put into it since early last fall. The Kennedy-Kassebaum legislation is indeed a complex and lengthy piece of legislation. As a result, this bill is lengthy and complex. It deals with numerous facets of the health insurance industry. In concept this bill maintains control of the insurance industry in the State Auditor's Office rather than forfeiting that control to the federal government. I believe that this is a good idea and believe that the committee would agree with that concept.

Operatively, I would like to talk about the requirement of "K-K", and that is continued health insurance be available to persons who already have insurance. In one or two sentences, that is what this bill is about. In so far as that single issue is concerned, it is contained in Section 17, 18, 19 and 20 which creates a portability pool for people under the Montana Comprehensive Health Association. That is the high risk pool that exists for people who are not able to obtain insurance otherwise in the State of Montana. This would create a separate pool under the auspices of the MCHA. This is an innovative type of mechanism for complying with "K-K" and there are a number of states who are following the lead of Montana.

What would happen is that there would be a separate pool in the MCHA and the premiums would be charged to the individuals who are in that pool and to the extent that the premiums, with caps placed on those premiums, are not sufficient to cover the claims and administrative costs, the insurers who are doing business in the state would be subject to an assessment to cover the unfunded liabilities. I realize that is a word that I should not be using but that is what it is. It would be paid by the insurance companies. Under the regular pool, the companies are allowed to take a premium tax offset for their assessments. That would not be allowed under the affordability pool. Basically, that is what

this bill does in so far as compliance with the individual market reforms. I would ask for a Do Pass.

**Kate Cholewa, MT Women's Lobby.** We rise in support of this bill. We have one concern and a suggested amendment (EXHIBIT 8 and 9).

**Claudia Clifford, Auditor's Office, Insurance Department.** I come as a proponent of SB 378. The Federal Act has consumed our office since its passage. The Act was amended twice by Congress in September which resulted in provisions that deal with maternity length of stay and mental health mandated benefits. I will hand out a copy of the Act (EXHIBIT 10). There are a lot of conflicts, questions and gray areas in the federal act. What we have done in the Insurance Dept. is what I bring to you as our best guess at implementing the provisions of the Federal Act. It is not a perfect bill. Attorney's will make a career out of interpreting various portions of the Act. You can expect Congress in the future to be doing both clean up language and perhaps expansion of this Act. It is true that insurance has been traditionally regulated at the state level and SB 378 allows us to implement the provisions of the Act and in essence helps our consumers here in Montana.

There are three federal agencies that have oversight over provisions of the Congressional Act. That is confusing for our consumers and for us as a Dept. None of these three agencies has the background or experience in the insurance field and so they are just learning terminology to basics. We are fortunate to have the National Association of Insurance Commissioners that help organize model acts which you may have heard before your committee. They serve as a very significant resource to the federal agencies and I cannot underestimate how important that is. The federal agencies have had numerous meetings with the NAIC on the training of what these issues are about. We receive information from the NAIC who are in direct communication with the federal agencies on the unclarified issues. We have a significant rule making that will be issued in April which, hopefully, will start to answer many of the questions that the states have put before Congress.

Back to SB 378, what we need to show in this session is our best effort as the State of Montana to bring ourselves into compliance with the Act and it is my belief that this bill will meet their muster and they will not preempt our state authority to regulate insurance and help our consumers. With this bill, we will have a new arrangement with the federal government, for good or bad. The provisions of the bill are broad; they affect all kinds of insurance plans. If you are use to dealing with state insurance law we are more narrow in our scope; we could not affect what are called the risk related exempt plans in the past. The Federal Act basically affects all kinds of insurance plans. I do have some very good background material. I have a one page handout that is a summary of provision in the Act the affect large group,

small group and individual plans (EXHIBIT 10A). This is a quick reference of how this bill affects our coverage in Montana.

There are four sections of this bill. There are sections on viatical settlements. Frank Cote can answer questions on this. There are provisions that deal with long term care insurance. Clyde Dailey can answer questions on this. I focus mostly on the group and individual market affordability provisions and also on the maternity length of stay issues.

I have a handout to help illustrate what Tom Hopgood covered in terms of what we did to design a mechanism for individual portability (EXHIBIT 11). The federal government gave the state choices in how they wanted to address the issue of an individual who is leaving a group plan and must have access to individual coverage called guaranteed issue: no waiting periods on their pre-existing conditions, no riders conditions, no rejections for coverage. We looked at alternatives. The one we settled on for this bill is the use of what we already have which is called the Montana Comprehensive Health Association. We will keep in place the traditional program under the MCHA. We are in essence creating a new book of business. This chart explains it. One of the reasons that it was set up as a new book of business was we needed to look at assessments as being separate from traditional assessments and we do not allow for assessments to be offset against premium tax for the new book of business. Therefore it will not affect the bottom line of your budget. This bill allows for the MCHA to be a revenue neutral bill.

We have an interesting relationship with the governor through the Congressional Act. In most states, the Insurance Commissioner is appointed by a governor and in only 13 states is the insurance commissioner separately elected. Congress designed this bill so that the Governor communicates to Congress on various issues of compliance. We are working closely with the Governor's office and our first big hurdle is to certify to the federal government that we selected to do a state alternative individual market mechanism which is this bill. We hope they will adopt our compliance as proposed.

I have one amendment to the bill (EXHIBIT 12). Various insurance agents agree that this is an important clarification for your consideration. It brings into compliance our definition of small group.

Laurie Ekanger, Director, Department of Public Health and Human Services, on behalf of the Governor's Office. I am here on behalf of Governor Racicot to urge your support of this bill. The governor has a small role in bringing the state into compliance. He urges your support.

Jim Malgram, Executive Director, MT Independent Living Project. We support the bill. We do have an amendment (EXHIBIT 13). We

would like to see the continuation of coverage for handicapped people.

**Al Smith, Executive Director, MT Advocacy Program.** We are in support of this legislation but would echo what Mr. Malgram has said.

**Bill Jensen, Blue Cross and Blue Shield of MT., and Chairman of Montana Comprehensive Health Association.** We appreciate all the work that has been done on this bill. The MCHA Board of Directors at the time of the "K-K" passage began looking at what kind of changes would be necessary to Montana law in order for MCHA to be available as an alternative mechanism. One thing we felt was important was to protect our currently insured people under MCHA. There are 400 Montanans insured under MCHA. They would be in a separate pool. We appreciate the innovative idea of a second pool.

**Jim Mitchell, Director, Student Health Service, MSU-Bozeman.** I will give my testimony and hand in a written copy. (EXHIBIT 13A)

**Ed Grogan, MT Medical Benefit Plan.** I commend the work of SEN. BENEDICT and the others who have worked on this bill. This is a good bill and urge your support of it.

Opponents' Testimony: None

{Tape: 1; Side: B; Approx. Time Count: 9:39 AM; Comments: N/A.}

Questions From Committee Members and Responses:

SEN. BEA MCCARTHY asked SEN. BENEDICT a series of questions. (1) On page 69, on viatical settlement, is this section 58 the same as SEN. VAN VALKENBURG'S bill? SEN. BENEDICT answered, "Substantially the same." (2) On maternity length of stay, has this been taken care of? SEN. BENEDICT answered, "Yes." (3) On page 8, line 8; what does transferring mean? SEN. BENEDICT explained that it means picking someone up and putting them into a wheelchair or onto a bed or to a bath chair, etc. It is different for a patient who can walk even with a walker. (4) On page 41, line 18, you spell out mammography and the mammogram treatment as a specific category, but where is the prostate program addressed? Both should be understood or both should be addressed. SEN. BENEDICT replied that evidently this was not a question to be answered and he was correct in that assumption.

SEN. DEBBIE SHEA asked about portability and would like to know if any of this bill is retroactive? Her ex-husband left his job and went into his own business. During that time period he was under the COBRA law which gave him 18 months. Also during that time, he developed MS. Now he cannot find insurance. Can he go back? SEN. BENEDICT said that it would depend on the break in the coverage. But ultimately he should be able to find insurance under the MCHA. Portability means from one insurance coverage to

another. A break in coverage is 63 days and then he could do something.

**SEN. CASEY EMERSON** related that when he sold insurance, the private industry handled their end of it. When government gets into the insurance business, this is not good and the Kennedy-Kassebaum Act is a bad bill. Do you feel the "K-K" is contrary to the aim of the U. S. and Montana State's Constitutions? **Mr. Hopgood** replied that is a complicated question which he is incapable of answering with a specific yes or no. It is a policy debate over the delivery of health care in the country and this state which has been on-going for some time and the subject of a great deal of deliberation and consideration by many people and he would decline to judge on that particular question. **SEN. EMERSON** said that he thinks it is a bad bill and does help ruin both constitutions. He further asked if the Legislature is legitimizing "K-K" by passing this bill? **Mr. Hopgood** replied that what is being done with this bill is maintaining control of the health insurance industry with the State Auditor's office rather than forfeiting that control to the federal government. **SEN. EMERSON** stated that **SEN. BENEDICT** has done a tremendous job on this bill and he is not putting either the **SENATOR** or the bill down. What the Legislature should be doing is challenging the federal government.

*{Tape: 2; Side: A; Approx. Time Count: 9:49 AM; Comments: N/A.}*

**SEN. JOHN HERTEL** asked if there are any conflicts with this particular piece of legislation at the federal level? **Ms. Clifford** replied that to the best of their knowledge, there are none.

Closing by Sponsor:

**SEN. BENEDICT** closed. This bill will alleviate for us great consternation what other states will find when they try to bring themselves into compliance with the "K-K" federal act. We are a bit ahead of the power curve having in 1993 and 1995 passed legislation aimed at "K-K". We are not being unduly forced to do a lot of things other states are going to have to grapple with. We have already made some of those policy decisions. This bill will just tweak a little bit and prove to the federal government that we have the ability to regulate insurance in our own state. That is a strong message to the federal government.

*{Tape: 2; Side: A; Approx. Time Count: 10:02 a.m.; Comments: N/A.}*

HEARING ON SB 381

Sponsor: SEN. STEVE BENEDICT, SD 30, Hamilton

Proponents: Ed Grogan, Montana Medical Benefit Plan

# MONTANA WOMEN'S LOBBY

P . O . B O X 1 0 9 9 H E L E N A , M T 5 9 6 2 4 4 0 6 - 4 4 9 - 7 9 1 7

SENATE BUSINESS & INDUSTRY  
EXHIBIT NO. 8  
DATE 1-20-97  
BILL NO. SB 378

SB 378

We would request you include the following amendment in SB 378:

Page 39. Following line 23

Insert: "(d) coverage for well child care required by 33-22-303, 33-22-512, and 33-20-1014;

(e) coverage for adopted children from time of placement required by 33-22-130; and

(F) coverage of newborns required by 33-22-301, 33-22-504, 33-30-1001.

These provisions are important to the basic health of children and infants. With the expansion of the small employer group, ~~We~~  
we believe it is important to include these benefits.

Thank you.

Proposed Amendments  
S.B. 378  
Introduced Bill Copy  
February 19, 1997

SENATE BUSINESS & INDUSTRY  
EXHIBIT NO. 9  
DATE 2-20-97  
BILL NO. \_\_\_\_\_

1. Page 39, line 22.

Strike: line 22 in its entirety

2. Page 39, line 23.

Strike: "."

Insert: ";

3. Page 39.

Following: line 23

Insert: "(d) coverage for well child care required by 33-22-303,  
33-22-512, and 33-20-1014;

(e) coverage for adopted children from time of placement  
required by 33-22-130; and

(f) coverage of newborns required by 33-22-301, 33-22-504,  
33-30-1001."

October 1996

SENATE BUSINESS & INDUSTRY

EXHIBIT NO. 10

DATE 2-20-97

BILL NO. SB 378

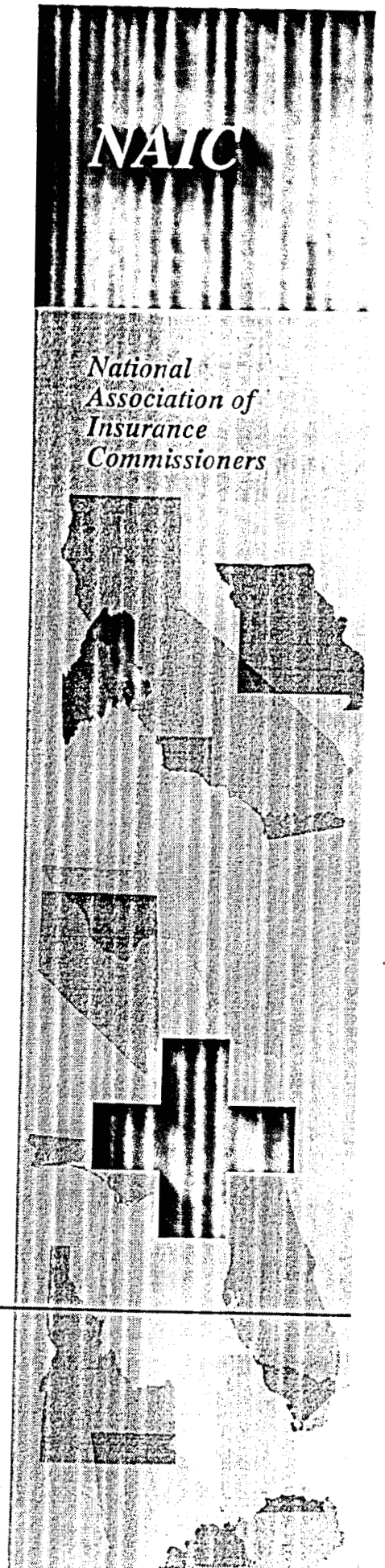
Exhibit # 10 - 80 pages

The full exhibit is available from:  
MT Historical Society Archives  
225 North Roberts  
P.O. Box 201201  
Helena, MT 59620-1201  
Phone # (406)444-4774

# Draft Template for State Implementation of the Health Insurance Portability and Accountability Act of 1996

**NAIC**

*National  
Association of  
Insurance  
Commissioners*





# HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996\* [P.L. 104-191]

SENATE BUSINESS & INDUSTRY

EXHIBIT NO. 10A

DATE 1-20-97

|                                            | Large Group                                                                                                        | Small Group<br>[2 - 50 Employees]                                                                                                                                                  | Individual <u>515378</u>                                                                                                                                                                                                                                          |
|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Guaranteed Issue                           | No<br><br>[§2711]**                                                                                                | Yes, of all products sold in small group market to whole group and eligible individuals within the group.<br>[§2711(a)(1)]                                                         | Yes, of a limited number of products to eligible individuals.<br><br>[§2741]                                                                                                                                                                                      |
| Guaranteed Renewability                    | Yes, with standard exceptions. [§2712]                                                                             | Yes, with standard exceptions. [§2712]                                                                                                                                             | Yes, with standard exceptions. [§2742]                                                                                                                                                                                                                            |
| Establishes Maximum PreX Exclusion Periods | Yes - 12 months (18 months for late enrollees). [§2701]                                                            | Yes - 12 months (18 months for late enrollees). [§2701]                                                                                                                            | Preexisting condition exclusions are prohibited for eligible individuals. [§2741]                                                                                                                                                                                 |
| Establishes Maximum Look-Back Periods      | Yes - 6 months.<br>[§2701]                                                                                         | Yes - 6 months.<br>[§2701]                                                                                                                                                         | Preexisting condition exclusions are prohibited for eligible individuals. [§2741]                                                                                                                                                                                 |
| Requires Credit for previous PreX          | Yes<br>[§2701(c)]                                                                                                  | Yes<br>[§2701(c)]                                                                                                                                                                  | Preexisting condition exclusions are prohibited for eligible individuals. [§2741]                                                                                                                                                                                 |
| Preemption of State Law in General         | No, unless state standard or requirement prevents application of K/K.<br>[§2723(a)]                                | No, unless state standard or requirement prevents application of K/K.<br>[§2723(a)]                                                                                                | Yes, unless state implements alternative mechanism.<br><br>[§§2741, 2744]                                                                                                                                                                                         |
| Preemption of State Law re: PreX           | Yes, unless state law fits one of several exemptions for state laws that are more generous re: PreX.<br>[§2723(b)] | Yes, unless state law fits one of several exemptions for state laws that are more generous re: PreX.<br>[§2723(b)]                                                                 | Yes; for eligible individuals, federal law prevents the application of any PreX exclusion.<br><br>[§§2741, 2744]                                                                                                                                                  |
| State Enforcement Permitted                | Yes, unless state fails to substantially enforce a provision.<br>[§2722]                                           | Yes, unless state fails to substantially enforce a provision.<br>[§2722]                                                                                                           | Yes, unless state fails to substantially enforce a provision.<br>[§2745]                                                                                                                                                                                          |
| Eligible Individual                        |                                                                                                                    | Is determined in accordance with terms of the plan, under rules of the issuer which are uniformly applicable and which comply with all applicable state laws.<br><br>[§2711(a)(2)] | -At least 18 months of previous "creditable" coverage;<br>- Most recent coverage in group plan;<br>- No lapse in coverage that exceeds 63 days;<br>- Has no current coverage;<br>- Not eligible for Medicare or Medicaid;<br>- Has exhausted COBRA.<br>[§2741(b)] |

|                                              | Large Group       | Small Group<br>[2 - 50 Employees] | Individual       |
|----------------------------------------------|-------------------|-----------------------------------|------------------|
| Maternity Provisions Apply<br>(48-Hour Stay) | Yes<br>[§2704]    | Yes<br>[§2704]                    | Yes<br>[§2751]   |
| Mental Health Parity<br>Provisions Apply     | Yes<br>[§2705(a)] | No<br>[§2705(c)(1)]               | No<br>[§2705(a)] |

\*This chart sets forth the minimum standards set forth within the Act. In most areas, state standards can go further than the minimum federal standards.

\*\* All references are to the Public Health Service Act (PHSA), as amended by P.L. 104-191, Title I, Sections 102, 111, and subsequent amendments thereto.

12/12/96

# MONTANA COMPREHENSIVE HEALTH ASSOCIATION

SENATE BUSINESS & INDUSTRY

EXHIBIT NO. 11

DATE 2-20-97

BILL NO. SB 378

## Traditional Plan

Implemented in 1985  
(33-22-Part 15)

### Eligibility

Rejected or offered restrictive rider by two  
insurers in last six months

Resident of Montana

### Rating Restrictions

Not to exceed 200 percent of average rates  
charged by five largest individual market carriers

Premium offset for assessments

## SB 378 New Book of Business Association Portability Plan

(For individuals leaving group coverage who desire full  
coverage; no exclusionary riders, no preexisting waiting period)

Two comprehensive plans offered

### Eligibility

Federally defined eligible individual  
(see pg. 49 of SB 378)

Must apply within 63 days following  
termination of prior coverage

### Rating Restrictions

Not to exceed 150 percent of average rates  
charged by five largest carriers, and for the  
first year not to be less than 135 percent

No premium offset for assessments  
(allows bill to be revenue neutral)

EXHIBIT NO. 11  
DATE 2-20-97  
BILL NO. SB 378

SENATE BUSINESS & INDUSTRY

Senate Bill 378  
Proposed Amendment, Introduced Bill Copy  
February 20, 1997

1. Page 26, line 13.  
Following: "and that,"  
Strike: "on a least 50% of its working days during the preceding calendar quarter"  
Insert: "with respect to a calendar year and a plan year"
  
2. Page 26, line 14.  
Following: "employees"  
Strike: ", the majority of whom were employed within this state or were residents of this state"  
Insert: "during the preceding calendar year and employed at least 2 employees on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees reasonably expected to be employed by the employer in the current calendar year"

Proposed Amendments  
S.B. 378  
Introduced Bill Copy  
February 19, 1997

SENATE BUSINESS & INDUSTRY

EXHIBIT NO. 13

DATE 2-20-97

BILL NO. S B 378

1. Page 39, line 22.

Strike: line 22 in its entirety

2. Page 39, line 23.

Strike: "."

Insert: "; and"

3. Page 39.

Following: line 23

Insert: "(d) continuation of coverage for handicapped required  
by 33-22-304, 33-22-506, and 33-30-1004."

**Testimony on Senate Bill 378**

**Montana Senate Committee on Business and Labor**

**February 20, 1997**

SENATE BUSINESS & INDUSTRY  
EXHIBIT NO. 13 A  
DATE 2-20-97  
BILL NO. SB 378

Good Morning. My name is Jim Mitchell and I am the Director of the Student Health Service at Montana State University - Bozeman. I am here in that capacity. I am also the President-elect of the American College Health Association and I am also here to present the position of that organization. Luckily, the positions of both organizations is the same, so I won't have to be schizophrenic as I make my presentation today.

I am speaking in support of this Bill as originally introduced.

Large numbers of the over 30,000 college students in the State of Montana are enrolled in health insurance plans sponsored by the campuses they attend. Currently, there are over 8,000 students on the campuses of MSU-Bozeman, MSU-Northern, UM-Missoula, and Montana Tech that participate in an insurance plan offered through a consortium of these 4 campuses.

We believe that it is critical for SB 378 to apply to college-sponsored health plans for students. As originally introduced, the Bill does this. However, I would like to take this opportunity to state the position of both MSU and ACHA in this regard.

First, we believe that the portability provisions of SB 378 should apply to

college-sponsored health plans for students. The reason for this is that S B 378 college students would benefit by being able to move from one insurance plan to another without having any "pre-existing conditions" excluded. This includes such things as moving from an employer-sponsored plan to a campus-sponsored plan, from a campus-sponsored plan to an employer-sponsored plan, from one campus-sponsored plan to another, and from a campus-sponsored plan to an individual plan.

Second, we believe that the time a student is covered by a college-sponsored health insurance plan should be counted as "creditable" coverage when a student leaves a particular college plan for another plan. Again, when a student moves off a college-sponsored plan onto a new plan, the period a student was covered by the college-sponsored plan should be considered "creditable previous coverage" to avoid any waiting periods before coverage of pre-existing conditions.

Finally, college sponsored plans for students should be considered as "group" plans (but not "employer-sponsored" group plans). "Group" status would assure the portability provisions outlined above.

Again, the Bill as, originally introduced, would lead to campus-sponsored plans for students being considered in a manner that would address the three points outlined above. I am thus supporting the Bill as originally introduced on behalf of MSU-Bozeman and the American College Health Association.

Thank you.

MINUTES

MONTANA SENATE  
55th LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & INDUSTRY

Call to Order: By CHAIRMAN JOHN HERTEL, on February 21, 1997, at  
9:00 A.M., in ROOM 410.

ROLL CALL

Members Present:

Sen. John R. Hertel, Chairman (R)  
Sen. Steve Benedict, Vice Chairman (R)  
Sen. Debbie Bowman Shea (D)  
Sen. William S. Crismore (R)  
Sen. C.A. Casey Emerson (R)  
Sen. Bea McCarthy (D)

Members Excused: None

Members Absent: None

Staff Present: Bart Campbell, Legislative Services Division  
Mary Gay Wells, Committee Secretary

Please Note: These are summary minutes. Testimony and  
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: SB 379; 2/18/97  
Executive Action: SB 379; SB 270; SB 378;  
SB 381; HB 117  
SB 376 DO NOT PASS

{Tape: 1; Side: A; Approx. Time Count: 9:01 AM; Comments: N/A.}

HEARING ON SB 379

Sponsor: SENATOR J. D. LYNCH, HD 19, BUTTE

Proponents: Jerry Loendorf, MT Consumer Finance Assoc.  
Donald Hutchinson, Department of Commerce, Banking  
& Financial

Opponents: None



Opening Statement by Sponsor:

SENATOR J. D. LYNCH, HD 19, BUTTE. SB 379 generally revises and updates certain provisions of the Montana Consumer Loan Act. The Montana Consumer Loan has never previously defined in the law and this bill now provides a definition. It would also allow certain loans to be repaid in other than equal installments and by the mortgager shall be released within 30 days after payment. There was an amendment that I hope you will consider. Thank you.

Proponents' Testimony:

Jerry Loendorf, MT Consumer Finance Assoc. The bill does what the sponsor just explained. I have a couple of amendments (EXHIBIT 1) that I will run through with you. They are very simple.

Don Hutchinson, Department of Commerce, Banking & Financial. I speak in support of the bill and the amendments. We request your support. Thank you.

Opponents' Testimony: None

Questions From Committee Members and Responses: None

Closing by Sponsor:

SEN. LYNCH closed.

EXECUTIVE ACTION ON SB 379

Motion: SEN. DEBBIE SHEA MOVED DO PASS SB 379.

Amendments: SEN. SHEA MOVED to Amend SB 379 (EXHIBIT 1) sb037901.abc.

Vote: The motion TO AMEND SB 379 CARRIED UNANIMOUSLY: 6-0

Motion/Vote: SEN. SHEA MOVED DO PASS AS AMENDED SB 379. The motion CARRIED UNANIMOUSLY: 6-0.

{Tape: 1; Side: A; Approx. Time Count: 9:09 AM; Comments: N/A.}

EXECUTIVE ACTION ON SB 378

Motion: SEN. STEVE BENEDICT MOVED DO PASS SB 378.

Amendments: SEN. BENEDICT MOVED to AMEND SB 378 (EXHIBIT 2) sb037801.abc.

Discussion: SEN. BENEDICT stated the amendments are for the purpose of catching something that had not been put into the original bill in its proper form. SEN. MCCARTHY asked if the amendments that Claudia Clifford, State Auditor's Office, proposed were considered and added? SEN. BENEDICT and Mr. Campbell explained that her amendments were part of (EXHIBIT 2).

Vote: The motion to AMEND SB 378 CARRIED UNANIMOUSLY: 6-0.

Discussion: SEN. DEBBIE SHEA asked in talking about the COBRA law, once you leave your insurance you have to exhaust the COBRA (18 months) before you go into the Montana Comprehensive Health Assoc. Is this correct and if is, is there any way it could be made optional? Ms. Clifford stated that you could make that optional. That would be a portability statement to say that once you have left a group you would not have to exhaust your COBRA before you were eligible for MCHA coverage. SEN. BENEDICT said he would like to see what the industry people felt about this suggestion. Mr. Chuck Butler, Blue Cross and Blue Shield, answered that he agrees with what Ms. Clifford says although COBRA is in place for a specific reason to give people that benefit to continue their coverage for a certain period of time. I would err on the side of staying as close as possible to the Kennedy-Kassebaum Act. A great deal of thought was given to the "K-K" and there must be some reason for their not putting something like this into the Act.

SEN. MCCARTHY asked about the two amendments that were proposed for handicapped people and for children? SEN. BENEDICT replied that he has always taken a stance against mandated benefits.

Motion/Vote: SEN. BENEDICT MOVED DO PASS AS AMENDED. The motion CARRIED UNANIMOUSLY: 6-0.

{Tape: 1; Side: A; Approx. Time Count: 9:19 AM; Comments: N/A.}

#### EXECUTIVE ACTION ON SB 381

Motion: SEN. BENEDICT MOVED DO PASS SB 381.

Discussion: SEN. BENEDICT explained that this bill was not intended to open up old policy decisions. SB 381 was to recodify a section from one part of the bill to another part of the bill. As far as he was concerned no other issues were pertinent in this discussion.

CHAIRMAN JOHN HERTEL asked Ms. Clifford to make a statement concerning this bill. Ms. Clifford said that she would like to correct one factual statement that was offered in testimony yesterday by a proponent of the bill. The uniform plan is a current law and can be offered by carriers. A statement yesterday said that without this bill uniform plans could not be

Amendments to Senate Bill No. 378  
First Reading CopyRequested by Senator Benedict  
For the Committee on Business and IndustryPrepared by Bart Campbell  
February 20, 1997

1. Page 7, line 13.

Strike: "(i)"

Insert: "(1)"

2. Page 7, line 29.

Strike: "3%"

Insert: "1%"

3. Page 26, lines 13 and 14.

Following: "and that,"

Strike: "on" on line 13 through "quarter" on line 14

Insert: "with respect to a calendar year and a plan year"

4. Page 26, lines 14 and 15.

Following: "employees"

Strike: ", the" on line 14 through "of this state" on line 15

Insert: "during the preceding calendar year and employed at least two employees on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer must be based on the average number of employees reasonably expected to be employed by the employer in the current calendar year"

## MINUTES

### MONTANA HOUSE OF REPRESENTATIVES 55th LEGISLATURE - REGULAR SESSION

#### COMMITTEE ON HUMAN SERVICES

**Call to Order:** By CHAIRMAN DUANE GRIMES, on March 14, 1997, at 3:00 P.M., in ROOM 104.

#### ROLL CALL

**Members Present:**

Rep. Duane Grimes, Chairman (R)  
Rep. Loren L. Soft, Vice Chairman (Majority) (R)  
Rep. Carolyn M. Squires, Vice Chairman (Minority) (D)  
Rep. Darrel Adams (R)  
Rep. Chris Ahner (R)  
Rep. Ellen Bergman (R)  
Rep. William E. Boharski (R)  
Rep. John C. Bohlinger (R)  
Rep. Deb Kottel (D)  
Rep. Billie Krenzler (D)  
Rep. Brad Molnar (R)  
Rep. Wes Prouse (R)  
Rep. Diane Sands (D)  
Rep. Bruce T. Simon (R)  
Rep. Liz Smith (R)

**Members Excused:** Rep. Carey

**Members Absent:** None

**Staff Present:** David Niss, Legislative Services Division  
Jaelene Racicot, Committee Secretary

**Committee Business Summary:**

Hearing(s) & Date(s) Posted: SB 378, SB 324, SJR 8  
Executive Action: SJR 8 DO CONCUR IN 11-0

#### HEARING ON SJR 8

**Opening Statement by Sponsor:**

REP. DIANE SANDS, HD 66, introduced the bill. {Tape: 1; Side: A;  
Approx. Time Count: .2.}

**Proponents' Testimony:**

Claudia Clifford, State Auditor's Office. {Tape: 1; Side: A; Approx. Time Count: 22.7.}

Tanya Ask, Blue Cross/Blue Shield. {Tape: 1; Side: A; Approx. Time Count: 24.4.}

Steve Yeakel, Montana Council for Maternal Health and the Montana Children's Alliance. {Tape: 1; Side: A; Approx. Time Count: 25.3.}

Jerry Loendorf, Montana Medical Association. {Tape: 1; Side: A; Approx. Time Count: 26.2.}

REP. Bruce Simon, HD 18. {Tape: 1; Side: A; Approx. Time Count: 27.1.}

Ed Grogan, Montana Medical Benefit Plan. {Tape: 1; Side: A; Approx. Time Count: 29.3.}

Opponents' Testimony:

None

Questions From Committee Members and Responses:

{Tape: 1; Side: A; Approx. Time Count: 29.9.}

Closing by Sponsor:

SEN. ESTRADA closed. {Tape: 1; Side: B; Approx. Time Count: 21.2.}

REP. GRIMES read a letter from the Department of Public Health and Human Services regarding the testimony by a proponent to HB 386.

REP. KOTTEL asked REP. GRIMES about the Drake amendment and why it was raised during the hearing on SB 324.

David Niss answered REP. KOTTEL'S concern on the Drake amendment.

HEARING ON SB 378

Opening Statement by Sponsor:

SEN. STEVE BENEDICT, SD 30, introduced the bill. {Tape: 2; Side: A; Approx. Time Count: 0.}

Proponents' Testimony:

Claudia Clifford, State Auditor's Office. {Tape: 2; Side: A;  
Approx. Time Count: 3.3; Comments: See EXHIBITS 4 & 5.}

REP. GRIMES stated the committee's structure would be different this meeting. He recommended members question Ms. Clifford as she proceeded to fully understand the bill. He asked if the committee understood the Montana Comprehensive Health Care Association was a high risk pool.

REP. BOHARSKI asked CLAUDIA CLIFFORD about adding a new book of business. She said the old book of business would stay the same and they were creating a new terminology as the insurance department book of business.

REP. BOHARSKI asked CLAUDIA CLIFFORD about coverage under the Kennedy-Kassebaum. She said in order to create coverage under Kennedy-Kassebaum (as required by each state)--the state commissioner would be the best placement for policy in the state of Montana.

REP. GRIMES asked CLAUDIA CLIFFORD to describe the options if the state didn't use the comprehensive health associations to the insurers. Ms. Clifford stated the other options provided under the congressional act were two model acts drafted by the NAIC. One act was very comprehensive having many products available on the individual market that guaranteed issue by the carriers. The other one made use of the Montana Comprehensive Health Care Association as first form of coverage for the federal qualified people. She stated a person could be under that coverage for a year and then they would go into a guaranteed issue market situation. Ms. Clifford stated these were major changes for the insurance market. Ms. Clifford commented that the carriers may not want to take on guaranteed issue in the individual market. The state would have a high risk pool and then it would be determined what would meet the needs of the federally qualified folks.

REP. BOHARSKI asked CLAUDIA CLIFFORD about the new book of business that Montana Comprehensive Health Care (MCHC) was going to be operating to cover this and if the funding would be the same? Ms. Clifford said that the premium tax would be deposited in the general fund and would not affect the general fund. She reminded the committee that all of the people involved would pay premiums for this type of coverage.

REP. SIMON stated that under the Montana Comprehensive Health Care Association current assessment plan, any assessment used would be an off-set against premium tax. SB 378 would change the procedure for this new book of business.

CLAUDIA CLIFFORD EXPLAINED THE AMENDMENTS. Ms. Clifford stated the first amendment was a suggestion by the Montana Loggers'

Association. They wanted to clarify the definition of associations with the federal act due to an inconsistency. The second amendment allowed the state to put into effect the Montana Comprehensive Health Care (MCHC) option, September 1, 1997, but allows the flexibility for the commissioner to waive implementation until January 1, 1998. The next amendment would clarify policies currently in effect which would come into compliance with the bill upon renewal, not while in forced. She stated there was a correction on the effective date of the mental health provisions to make it consistent with the federal act which would be January 1, 1998. The provisions dealing with the mental health statute bring it into compliance with an amendment added in September to the Federal Portability Act that would provide a form of parity for mental health benefits if it would not exceed 1% cost of a premium. It dealt with annual and lifetime benefits being in parity with annual and lifetime benefits for physical illness. She explained there was a sunset on that provision and in the federal act.

REP. BOHARSKI asked CLAUDIA CLIFFORD if there was any attempt to assess that effect on the mental health mandate on the policies in the state of Montana, if compliance is less than 1%. Ms. Clifford stated the carriers would not have to comply if they determine it would be more than a 1% increase in premiums.

REP. BOHARSKI asked CLAUDIA CLIFFORD if the carriers would submit to the State Auditor's Office a verification if it happened. Ms. Clifford stated that it was not clear at this time how they would handle it. Ms. Clifford stated there was rule making authority in the bill because three federal agencies who are going to be administering the bill are expected to issue rules April 1, 1997. Ms. Clifford stated that the Auditor's Office will then determine what the federal rules will be and then address the issues at hand.

Susan Good, Montana Association of Life Underwriters. {Tape: 2; Side: A; Approx. Time Count: 26.0.}

Tanya Ask, Blue Cross/Blue Shield. {Tape: 2; Side: A; Approx. Time Count: 26.8.}

Anita Bennet, Montana Logging Association. {Tape: 2; Side: A; Approx. Time Count: 30.0; Comments: Ms. Bennet did not testify. Ms. Ask handed her testimony in for the committee's consideration. See EXHIBIT 6.}

Laurie Ekanger, Governor's Administration. {Tape: 2; Side: A; Approx. Time Count: 30.2.}

Jerry Loendorf testified on behalf of Tom Ebzery, Yellowstone Community Health Plan. {Tape: 2; Side: A; Approx. Time Count: 30.7.}

Kate Cholewa, Montana Women's Lobby. {Tape: 2; Side: A; Approx. Time Count: 31.1.}

Tom Hopgood, Health Insurance Association of America. {Tape: 2; Side: B; Approx. Time Count: 0.}

Jim Mitchell, Director of the Student Health Service at Montana State University - Bozeman. {Tape: 2; Side: B; Approx. Time Count: 5.6; Comments: See EXHIBIT 7.}

Ed Grogan, Montana Medical Benefit Plan. {Tape: 2; Side: B; Approx. Time Count: 7.9; Comments: See EXHIBITS 8A, 8B, & 8C.}

Opponents' Testimony:

None

Questions From Committee Members and Responses:

{Tape: 2; Side: B; Approx. Time Count: 15.2 through to Tape: 3; Side: B; Approx. Time Count: 8.4.}

Closing by Sponsor:

SEN. BENEDICT closed. {Tape: 3; Side: B; Approx. Time Count: 8.4.}



**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY  
ACT OF 1996\* (P.L. 104-191)**

|                                            | Large Group                                                                                          | Small Group<br>(2 - 50 Employees)                                                                                                                             | Individual                                                                                                                                                                                                                                        |
|--------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Guaranteed Issue                           | No                                                                                                   | Yes, of all products sold in small group market to whole group and eligible individuals within the group                                                      | Yes, of a limited number of products to eligible individuals                                                                                                                                                                                      |
| Guaranteed Renewability                    | Yes, with standard exceptions                                                                        | Yes, with standard exceptions                                                                                                                                 | Yes, with standard exceptions                                                                                                                                                                                                                     |
| Establishes Maximum PreX Exclusion Periods | Yes - 12 months                                                                                      | Yes - 12 months                                                                                                                                               | Preexisting condition exclusions are prohibited for eligible individuals.                                                                                                                                                                         |
| Requires Credit for previous PreX          | Yes                                                                                                  | Yes                                                                                                                                                           | Preexisting condition exclusions are prohibited for eligible individuals.                                                                                                                                                                         |
| Preemption of State Law in General         | No, unless state standard or requirement prevents application of K/K.                                | No, unless state standard or requirement prevents application of K/K.                                                                                         | Yes, unless state implements alternative mechanism.                                                                                                                                                                                               |
| Preemption of State Law re: PreX           | Yes, unless state law fits one of several exemptions for state laws that are more generous re: PreX. | Yes, unless state law fits one of several exemptions for state laws that are more generous re: PreX.                                                          | Yes; for eligible individuals, federal law prevents the application of any PreX exclusion.                                                                                                                                                        |
| State Enforcement                          | Yes, unless state fails to substantially enforce a provision.                                        | Yes, unless state fails to substantially enforce a provision.                                                                                                 | Yes, unless state fails to substantially enforce a provision.                                                                                                                                                                                     |
| Eligible Individual                        |                                                                                                      | Is determined in accordance with terms of the plan, under rules of the issuer which are uniformly applicable and which comply with all applicable state laws. | -At least 18 months of previous "creditable" coverage;<br>- Most recent coverage in group plan;<br>- No lapse in coverage that exceeds 63 days;<br>- Has no current coverage;<br>-Not eligible for Medicare or Medicaid;<br>-Has exhausted COBRA. |
| Maternity Provisions Apply                 | Yes                                                                                                  | Yes                                                                                                                                                           | Yes                                                                                                                                                                                                                                               |
| Mental Health Parity Provisions Apply      | Yes                                                                                                  | Yes                                                                                                                                                           | No                                                                                                                                                                                                                                                |

\*This chart sets forth the minimum standards set forth within the Act. In most areas, state standards can go further than the minimum federal standards.

g:\data\mbs\misc\act96.doc

EXHIBIT 5  
DATE 3-14-97  
SB 378

## MONTANA COMPREHENSIVE HEALTH ASSOCIATION

### Traditional Plan

Implemented in 1985  
(33-22-Part 15)

#### Eligibility

Rejected or offered restrictive rider by two  
insurers in last six months

Resident of Montana

#### Rating Restrictions

Not to exceed 200 percent of average rates  
charged by five largest individual market carriers

Premium offset for assessments

### SB 378

### New Book of Business

#### *Association Portability Plan*

(For individuals leaving group coverage who desire full  
coverage; no exclusionary riders, no preexisting waiting period)

Two comprehensive plans offered

#### Eligibility

Federally defined eligible individual  
(see pg. 49 of SB 378)

Must apply within 63 days following  
termination of prior coverage

#### Rating Restrictions

Not to exceed 150 percent of average rates  
charged by five largest carriers, and for the  
first year not to be less than 135 percent

No premium offset for assessments  
(allows bill to be revenue neutral)



EXHIBIT

DATE

NO.

6

3-14-97

378

P.O. Box 1716  
Kalispell, MT 59903  
FAX (406) 756-9574  
(406) 752-3168

## SB 378

### AN ACT GENERALLY REVISING INSURANCE LAWS; REVISING INSURANCE LAWS TO COMPLY WITH PUBLIC LAW 104-191 ...

Mr. Chairman, Members of the House Human Services:

My name is Anita Bennett; and I am presenting testimony on HB-46 on behalf of M.L.A. Services, Inc., a subsidiary of the Montana Logging Association.

On their behalf, I have the following amendment. SB 378 has the new federal definition of a bona fide association on page 23, lines 2 through 12. However, on page 26, lines 27 through 30 and on page 27, lines 1 through 6 another definition of a bona fide association is listed within the definition of "Small Employer". The following technical correction is requested:

Page 26 line 27, strike ... that: insert a period.

Strike line 28, 29, and 30

Page 27 Strike: lines 1, 2, 3, 4, 5, 6.

Thank you for your attention to this technical correction.

**Testimony on Senate Bill 378**  
**Montana House Committee on Human Services**  
**March 14, 1997**

EXHIBIT 7  
DATE 3-14-97  
SB 378

Good Afternoon. My name is Jim Mitchell and I am the Director of the Student Health Service at Montana State University - Bozeman. I am here in that capacity. I am also the President-elect of the American College Health Association and I am also here to present the position of that organization. ~~I think the positions of both organizations is the same, so I won't have to be schizophrenic as I make my presentation today.~~

~~\_\_\_\_\_~~  
I am speaking in support of this Bill, ~~as originally introduced.~~

Large numbers of the over 30,000 college students in the State of Montana are enrolled in health insurance plans sponsored by the campuses they attend. Currently, there are over 8,000 students on the campuses of MSU-Bozeman, MSU-Northern, UM-Missoula, and Montana Tech that participate in an insurance plan offered through a consortium of these 4 campuses.

We believe that it is critical for SB 378 to apply to college-sponsored health plans for students. As passed by the Senate, the Bill does this. However, I would like to take this opportunity to state the position of both MSU and ACHA in this regard.

First, we believe that the portability provisions of SB 378 should apply to college-sponsored health plans for students. The reason for this is that

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college students would benefit by being able to move from one insurance plan to another without having any "pre-existing conditions" excluded. This includes such things as moving from an employer-sponsored plan to a campus-sponsored plan, from a campus-sponsored plan to an employer-sponsored plan, from one campus-sponsored plan to another, and from a campus-sponsored plan to an individual plan.

Second, we believe that the time a student is covered by a college-sponsored health insurance plan should be counted as "creditable" coverage when a student leaves a particular college plan for another plan. Again, when a student moves off a college-sponsored plan onto a new plan, the period a student was covered by the college-sponsored plan should be considered "creditable previous coverage" to avoid any waiting periods before coverage of pre-existing conditions.

Finally, college sponsored plans for students should be considered as "group" plans (but not "employer-sponsored" group plans). "Group" status would assure the portability provisions outlined above.

Again, the Bill, ~~as passed by the Senate~~, would lead to campus-sponsored plans for students being considered in a manner that would address the three points outlined above. I am thus supporting the Bill, ~~as originally introduced~~, on behalf of MSU-Bozeman and the American College Health Association.

Thank you.

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JOHN P. CRAWFORD  
INSURANCE COMMISSIONER  
STATE OF OKLAHOMA

EXHIBIT 8A  
DATE 3-14-97  
SB 378

February 28, 1997

Mr. Ed Grogan  
Montana Medical Benefits Plan  
Post Office Box 548  
Kalispell, MT 59903

Dear Mr. Grogan:

Thank you for your recent phone call. I appreciate your interest and concern in the interpretations of Kassebaum - Kennedy. The Oklahoma Insurance Department has proposed Senate Bill 193 as a vehicle to change Title 36, the Oklahoma Insurance Code, to come into compliance with the provisions of Public Law 104-191. I have included a copy of this bill. Please note that this bill is still the infancy stages of the legislative process. I am sure that further changes will be made. Because of this, the small group issue has not been included in this bill at this time.

With respect to the guarantee issue of small group products, it is the position of the Oklahoma Insurance Department that there has been no directive from HCFA at this point. We interpret the bill to say that small group must guarantee at least a standard and a basic plan. We do not agree with the NAIC's apparent interpretation of PL 104-191 as saying that small group must guarantee issue *all products*.

Recently, other states including Ohio and Nebraska agreed with the Oklahoma Department that there is little documented evidence from HCFA declaring that they are going to require guarantee issue of all plans.

If I can provide any further assistance or if you have questions, feel free to call.

Cordially,  
JOHN P. CRAWFORD  
Insurance Commissioner

Patrick B. Gaines  
Special Assistant to the Commissioner

1 (6) The commissioner may not require prior approval of the rating methods used by small employer  
2 carriers or the premium rates of the health benefit plans offered to small employers."

3

4 Section 24. Section 33-22-1811, MCA, is amended to read:

5 "33-22-1811. Availability of coverage -- required plans. (1) (a) As a condition of transacting  
6 business in this state with small employers, each small employer carrier ~~shall offer to small employers~~ *must*  
7 have approved for issuance to small employer groups at least two health benefit plans. One plan must be  
8 a basic health benefit plan, and one plan must be a standard health benefit plan.

9 (b) (i) A small employer carrier shall ~~offer~~ *offer* a basic health benefit plan or a standard health benefit  
10 plan to any eligible small employer that applies for either ~~a~~ *either* plan and agrees to make the required premium  
11 payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this  
12 part.

13 (ii) In the case of a small employer carrier that establishes more than one class of business pursuant  
14 to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one  
15 basic health benefit plan and at least one standard health benefit plan in each established class of business.  
16 A small employer carrier may apply reasonable criteria in determining whether to accept a small employer  
17 into a class of business, provided that:

18 (A) the criteria are not intended to discourage or prevent acceptance of small employers applying  
19 for a ~~basic or standard~~ health benefit plan;

20 (B) the criteria are not related to the health status or claims experience of the small employers'  
21 employees;

22 (C) the criteria are applied consistently to all small employers that apply for coverage in that class  
23 of business; and

24 (D) the small employer carrier provides for the acceptance of all eligible small employers into one  
25 or more classes of business.

26 (iii) The provisions of subsection (1)(b)(i) may not be applied to a class of business into which the  
27 small employer carrier is no longer enrolling new small businesses.

28 (c) A small employer carrier that elects not to comply with the requirements of subsections (1)(a)  
29 and (1)(b) may continue to provide coverage under health benefit plans previously issued to small employers  
30 in this state for a period of no more than 7 years from October 1, 1995, if the carrier:

## MINUTES

### MONTANA HOUSE OF REPRESENTATIVES 55th LEGISLATURE - REGULAR SESSION

#### COMMITTEE ON HUMAN SERVICES

**Call to Order:** By CHAIRMAN DUANE GRIMES, on March 27, 1997, at 7:00 A.M., in ROOM 108.

#### ROLL CALL

**Members Present:**

Rep. Duane Grimes, Chairman (R)  
Rep. Loren L. Soft, Vice Chairman (Majority) (R)  
Rep. Carolyn M. Squires, Vice Chairman (Minority) (D)  
Rep. Darrel Adams (R)  
Rep. Ellen Bergman (R)  
Rep. William E. Boharski (R)  
Rep. John C. Bohlinger (R)  
Rep. Bill Carey (D)  
Rep. Deb Kottel (D)  
Rep. Billie Krenzler (D)  
Rep. Brad Molnar (R)  
Rep. Wes Prouse (R)  
Rep. Diane Sands (D)  
Rep. Liz Smith (R)

**Members Excused:** Rep. Ahner & Rep. Simon

**Members Absent:** None

**Staff Present:** David Niss, Legislative Services Division  
Jaelene Racicot, Committee Secretary

**Committee Business Summary:**

Hearing(s) & Date(s) Posted: SJR 16 (3-25-97)  
Executive Action: SB 378 Be Concurred In As  
Amended 10 - 6.

REP. GRIMES explained the committee would hear SJR 16 and then begin taking executive action SB 378.

#### HEARING ON SJR 16

**Opening Statement by Sponsor:**

SEN. DEBBIE BOWMAN SHEA, SD 18, introduced the bill. {Tape: 1;  
Side: A; Approx. Time Count: .8.}



REP. ADAMS. {Tape: 1; Side: B; Approx. Time Count: 12.1.}  
REP. MOLNAR. {Tape: 1; Side: B; Approx. Time Count: 12.6.}  
REP. BOHLINGER. {Tape: 1; Side: B; Approx. Time Count: 14.4.}  
REP. BERGMAN. {Tape: 1; Side: B; Approx. Time Count: 16.0.}  
REP. BOHARSKI. {Tape: 1; Side: B; Approx. Time Count: 17.9.}  
REP. SOFT. {Tape: 1; Side: B; Approx. Time Count: 19.2;  
Comments: Questioned REP. MOLNAR.}

Motion: REP. BOHARSKI MOVED TO TABLE SJR 16. {Tape: 1; Side: B;  
Approx. Time Count: 21.0.}

Discussion:

REP. SMITH. {Tape: 1; Side: B; Approx. Time Count: 21.1;  
Comments: Questioned REP. GRIMES.}  
REP. SQUIRES. {Tape: 1; Side: B; Approx. Time Count: 21.7.}  
REP. BERGMAN. {Tape: 1; Side: B; Approx. Time Count: 22.7.}  
REP. BOHARSKI. {Tape: 1; Side: B; Approx. Time Count: 23.0.}

Vote: A ROLL CALL VOTE WAS TAKEN. THE MOTION FAILED 7 - 8.  
{Tape: 1; Side: B; Approx. Time Count: 25.8.}

Motion/Vote: REP. KOTTEL MOVED SJR 16 BE CONCURRED IN. A ROLL  
CALL VOTE WAS TAKEN. THE MOTION FAILED 7 - 8. {Tape: 1; Side:  
B; Approx. Time Count: 26.3.}

Discussion: REP. GRIMES STATED THE GOVERNOR OFFERED AN AMENDMENT  
TO HB 66. THE COMMITTEE CONCURRED WITH THE GOVERNOR'S  
SUGGESTION. {Tape: 1; Side: B; Approx. Time Count: 27.6.}

EXECUTIVE ACTION ON SB 378

Motion: REP. SMITH MOVED SB 378 BE CONCURRED IN. {Tape: 2;  
Side: A; Approx. Time Count: .3.}

Discussion:

REP. SANDS. {Tape: 2; Side: A; Approx. Time Count: .9.}

Motion/Vote: REP. GRIMES MOVED THE GRIMES AMENDMENT. THE MOTION  
CARRIED UNANIMOUSLY. {Tape: 2; Side: A; Approx. Time Count:  
1.2.}

Discussion:

REP. BOHARSKI. {Tape: 2; Side: A; Approx. Time Count: 2.8.}

Motion: REP. SANDS MOVED SB 378 BE CONCURRED IN AS AMENDED.  
{Tape: 2; Side: A; Approx. Time Count: 4.3.}

Discussion:

REP. GRIMES. {Tape: 2; Side: A; Approx. Time Count: 4.5.}

Motion/Vote: REP. SANDS MOVED THE STATE AUDITOR'S AMENDMENTS.  
THE MOTION CARRIED. {Tape: 2; Side: A; Approx. Time Count: 4.8.}

Discussion:

Tanya Ask, Blue Cross/Blue Shield was asked to comment on the amendments. {Tape: 2; Side: A; Approx. Time Count: 5.5.}

REP. GRIMES. {Tape: 2; Side: A; Approx. Time Count: 6.0.}

Motion: REP. SANDS MOVED SB 378 BE CONCURRED IN AS AMENDED.  
{Tape: 2; Side: A; Approx. Time Count: 6.1.}

Discussion:

David Niss. {Tape: 2; Side: A; Approx. Time Count: 7.0.}

Motion/Vote: REP. GRIMES MOVED TO AMEND SB 378. THE MOTION CARRIED.

Motion: REP. SANDS MOVED SB 378 BE CONCURRED IN AS AMENDED.  
{Tape: 2; Side: A; Approx. Time Count: 7.2.}

Discussion:

REP. BERGMAN. {Tape: 2; Side: A; Approx. Time Count: 7.7.}

REP. GRIMES. {Tape: 2; Side: A; Approx. Time Count: 8.7.}

REP. BOHARSKI. {Tape: 2; Side: A; Approx. Time Count: 9.0.}

David Niss. {Tape: 2; Side: A; Approx. Time Count: 9.2.}

REP. BOHARSKI. {Tape: 2; Side: A; Approx. Time Count: 9.7;  
Comments: Questioned David Niss.}

REP. SANDS. {Tape: 2; Side: A; Approx. Time Count: 11.3.}

REP. GRIMES. {Tape: 2; Side: A; Approx. Time Count: 11.4.}

Motion: REP. MOLNAR MOVED TO AMEND SB 378. {Tape: 2; Side: A;  
Approx. Time Count: 11.8.}

Discussion:

REP. GRIMES. {Tape: 2; Side: A; Approx. Time Count: 13.1.}

REP. BOHARSKI. {Tape: 2; Side: A; Approx. Time Count: 13.5;  
Comments: Questioned REP. MOLNAR.}

REP. KOTTEL. {Tape: 2; Side: A; Approx. Time Count: 15.7.}

Motion/Vote: REP. BOHARSKI OFFERED A SUBSTITUTE MOTION AND MOVED  
TO AMEND SB 378. A ROLL CALL VOTE WAS TAKEN. THE MOTION CARRIED  
8 - 7. {Tape: 2; Side: A; Approx. Time Count: 16.5.}

David Niss. {Tape: 2; Side: A; Approx. Time Count: 17.0.}

Motion: REP. GRIMES MOVED SB 378 BE CONCURRED IN AS AMENDED.  
{Tape: 2; Side: A; Approx. Time Count: 19.3.}

The committee reconsidered action on SB 378 later in the day.

## SENATE BILL NO. 378

INTRODUCED BY BENEDICT, SIMON, EMERSON, SPRAGUE, FOSTER, CHRISTIAENS

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING INSURANCE LAWS; REVISING INSURANCE LAWS TO COMPLY WITH PUBLIC LAW 104-191; PROHIBITING THE USE OF PREEXISTING CONDITION EXCLUSIONS AS THOSE EXCLUSIONS APPLY TO CERTAIN ELIGIBLE INDIVIDUALS; REGULATING LONG-TERM CARE INSURANCE CONTRACTS; REVISING THE MONTANA COMPREHENSIVE HEALTH CARE ASSOCIATION PLAN TO PROVIDE FOR AN ASSOCIATION PORTABILITY PLAN TO COMPLY WITH PUBLIC LAW 104-191; REVISING THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT; PROVIDING FOR GUARANTEED RENEWABILITY OF INDIVIDUAL AND GROUP HEALTH INSURANCE COVERAGE; ~~ENACTING THE VIATICAL SETTLEMENT ACT; PROVIDING FOR LICENSURE OF VIATICAL SETTLEMENT BROKERS; REGULATING VIATICAL SETTLEMENT CONTRACTS;~~ AUTHORIZING THE COMMISSIONER OF INSURANCE TO ADOPT RULES; ~~REQUIRING COVERAGE FOR A MINIMUM HOSPITAL STAY FOLLOWING CHILDBIRTH;~~ AMENDING SECTIONS 33-15-403, 33-20-128, 33-22-101, 33-22-109, 33-22-110, 33-22-130, 33-22-242, 33-22-504, 33-22-703, 33-22-1107, 33-22-1108, 33-22-1111, 33-22-1113, 33-22-1114, 33-22-1115, 33-22-1121, 33-22-1501, 33-22-1512, 33-22-1513, 33-22-1516, 33-22-1803, 33-22-1804, 33-22-1809, 33-22-1811, 33-22-1819, 33-22-1827, 33-22-1828, 33-30-1001, 33-31-102, 33-31-111, ~~33-31-301,~~ 33-31-322, AND 33-35-306, MCA; AND PROVIDING EFFECTIVE DATES, APPLICABILITY DATES, AND A TERMINATION DATE."

## STATEMENT OF INTENT

A statement of intent is required for this bill because [~~sections~~ SECTION 46 45 and 61] authorize ~~or require~~ AUTHORIZES OR REQUIRES rules to be adopted by the commissioner of insurance to implement various sections of [this act].

It is the intent of the legislature that rules adopted pursuant to [section ~~46~~ 45] not extend the existing control and regulatory authority of the state auditor beyond that necessary to implement Public Law 104-191.

~~The rulemaking authority provided in [section 61] is consistent with the requirements of Public Law 104-191, which provides for the adoption of standards promulgated by the national association of insurance commissioners. In adopting rules, the commissioner is to establish trade practice standards for~~

~~regulating advertising and solicitation of viatical settlement contracts, for evaluating reasonableness of payments under viatical settlement contracts, and for determining the forms necessary to effectively administer [sections 47 through 61]. The rules adopted should be consistent with any regulations adopted under Public Law 104-191.~~

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

**Section 1.** Section 33-15-403, MCA, is amended to read:

**"33-15-403. Representations in applications -- recovery precluded if fraudulent or material.** (1) All statements and descriptions in any application for an insurance policy or annuity contract or in negotiations ~~therefor~~ for an insurance policy or annuity contract by or ~~in~~ on behalf of the insured or annuitant ~~shall be deemed to be~~ are considered representations and not warranties.

(2) Misrepresentations, omissions, concealment of facts, and incorrect statements ~~shall~~ do not prevent a recovery under the policy or contract unless ~~either~~:

(a) fraudulent;

(b) material either to the acceptance of the risk or to the hazard assumed by the insurer; or

(c) the insurer in good faith would either not have issued the policy or contract or would not have issued a policy or contract in as large an amount or at the same premium or rate or would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

(3) Subsection (2)(c) does not apply to nonrenewal or discontinuation of group health insurance offered in connection with a group health plan in the small group market or large group market, as those terms are defined in [section 34 33]."

**Section 2.** Section 33-20-128, MCA, is amended to read:

**"33-20-128. Life insurance policy paying long-term benefits -- ~~quarterly~~ monthly report.** When a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a ~~quarterly~~ monthly report must be provided to the policyholder. The report must include the following information for the month for which the report is issued:

(1) the amount of long-term care benefits paid out during ~~each~~ the month ~~of the quarter~~;

- (2) an explanation of any changes in the policy, including without limitation death benefits or cash values, resulting from long-term care benefits having been paid out; and
- (3) the amount of long-term care benefits existing or remaining."

**Section 3.** Section 33-22-101, MCA, is amended to read:

**"33-22-101. Exceptions to scope.** Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-130 through 33-22-132, [section 35 34], [section 37 36], 33-22-243, and 33-22-304, do not apply to or affect:

- (1) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;
- (2) any group or blanket policy;
- (3) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance as:
- (a) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or
- (b) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract;
- (4) reinsurance."

**Section 4.** Section 33-22-109, MCA, is amended to read:

**"33-22-109. Riders.** (1) Except for ~~a policy issued under chapter 22, part 18~~ group health insurance coverage provided by a group health plan or a health insurance issuer, a policy of disability insurance may contain a provision that excludes coverage for specific conditions through the use of elimination riders for conditions for which medical advice, diagnosis, care, or treatment was recommended by or received from a provider of health care services within 4 3 years preceding the effective date of coverage of an insured person. The provisions of 33-22-110 do not apply to elimination riders. An insured person may apply to the insurer for removal or modification of a rider, and the insurer shall respond to the application within 60 days of receipt.

- (2) An insurer may not, except upon agreement by the insured, retroactively impose an elimination

1 rider on an existing policy, certificate, or contract.

2 ~~(3) "Elimination rider" means a provision attached to a policy that excludes coverage for a specific~~  
3 ~~condition that would otherwise be covered under the policy."~~

4  
5 **Section 5.** Section 33-22-110, MCA, is amended to read:

6 **"33-22-110. Preexisting conditions.** (1) Except as provided in ~~subsection (2)~~ [sections 38 and 40  
7 37 AND 39], a policy or certificate of disability insurance may not exclude coverage for a condition for  
8 which medical advice or treatment was recommended by or received from a provider of health care services  
9 unless the condition occurred within 5 years preceding the effective date of coverage of an insured person.  
10 The condition may only be excluded for a maximum of 12 months.

11 ~~(2) A health benefit plan may not exclude coverage for a condition for which medical advice or~~  
12 ~~treatment was recommended by or received from a provider of health care services unless the condition~~  
13 ~~occurred within 3 years preceding the effective date of coverage of an insured person. The condition may~~  
14 ~~be excluded for a maximum of 12 months.~~

15 ~~(3) For purposes of subsection (2), a "health benefit plan" means a hospital expense incurred or~~  
16 ~~medical expense incurred policy, contract, or certificate provided by a health insurer, health service~~  
17 ~~corporation, or health maintenance organization.~~

18 ~~(4)~~(2) An insurer may use an application form designed to elicit the complete health history of an  
19 applicant and, on the basis of the answers on that application, perform underwriting in accordance with  
20 the insurer's established underwriting standards.

21 ~~(5)~~(3) A policy of disability income insurance may not exclude coverage for a condition for which  
22 medical advice or treatment was recommended by or received from a provider of health care services unless  
23 the condition occurred within 5 years preceding the effective date of coverage of an insured person. An  
24 exclusion may not apply to a disability commencing more than 12 months from the effective date of  
25 coverage of an insured person."

26  
27 **Section 6.** Section 33-22-130, MCA, is amended to read:

28 **"33-22-130. Coverage for adopted children from time of placement -- preexisting conditions.** (1)  
29 Each group and individual disability policy, certificate of insurance, or membership contract that is delivered,  
30 issued for delivery, renewed, extended, or modified in this state must provide coverage for an adopted child

of the insured or subscriber to the same extent as for natural children of the insured or subscriber.

(2) The coverage required by this section must be effective from the date of placement for the purpose of adoption and must continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage at the time of placement must include the necessary care and treatment of medical conditions existing prior to the date of placement and may not impose a preexisting condition exclusion.

(3) As used in this section, "placement" means placement for adoption as defined in 40-8-103."

**Section 7.** Section 33-22-242, MCA, is amended to read:

**"33-22-242. Waiver of preexisting condition exclusion -- exclusion prohibited.** (1) A health care insurer shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health benefit plan for the period of time that an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services, if the qualifying previous coverage was continuous to a date not more than 30 days prior to the date of application for new coverage.

(2) A health care insurer that offers individual health insurance coverage to a federally defined eligible individual may not impose a preexisting condition exclusion with respect to that coverage."

**Section 8.** Section 33-22-504, MCA, is amended to read:

**"33-22-504. Newborn infant coverage.** (1) A group disability policy or certificate of insurance delivered or issued for delivery in this state may not be issued or amended in this state if it contains any disclaimer, waiver, preexisting condition exclusion, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of persons covered under the policy from and after the moment of birth.

(2) A policy or certificate subject to this section, must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any person covered under the policy.

(3) The coverage for newborn infants must be the same as provided by the policy for other covered persons. However, for newborn infants there may not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms



1 and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

2 (4) This section does not apply to medicare supplement policies issued by reason of age.

3 (5) When a group disability policy or certificate issued under the policy provides for coverage or  
4 benefits for a resident of this state, the policy or certificate is considered delivered in this state within the  
5 meaning of this section regardless of whether the insurer issuing the policy or certificate is located in this  
6 state.

7 (6) The policy or certificate may require notification of the birth of a child and payment of a  
8 required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation  
9 within 31 days of the birth in order to have the coverage extend beyond 31 days."

10  
11 **Section 9.** Section 33-22-703, MCA, is amended to read:

12 **"33-22-703. Coverage for mental illness, alcoholism, and drug addiction.** ~~Insurers, health service~~  
13 ~~corporations, or any employees' health and welfare fund that provides accident and health insurance~~  
14 ~~benefits to residents of this state under group health insurance or group health plans shall provide, for~~  
15 ~~Montana residents covered under hospital and medical expenses incurred insurance group policies and~~  
16 ~~under hospital and medical service plan group contracts, the~~ (1) A group health plan or a health insurance  
17 issuer that provides group health insurance coverage shall provide for Montana residents covered by the  
18 plan at least the following level of benefits specified in this section for the necessary care and treatment  
19 of mental illness, alcoholism, and drug addiction, ~~subject to the right of the applicant to select any~~  
20 ~~alternative level of benefits above the minimum level of benefits described in subsections (1)(c), (2)(a),~~  
21 ~~(2)(c), (2)(d), and (2)(e) as may be offered by the insurer or health service corporation:~~

22 (1)(a) under basic inpatient expense policies or contracts, inpatient hospital benefits consisting of  
23 durational limits, dollar limits, deductibles, and coinsurance factors that are not less favorable than for  
24 physical illness generally, except that:

25 (a)(i) inpatient treatment for mental illness, alcoholism, and drug addiction is subject to a maximum  
26 yearly benefit of 21 days;

27 (b)(ii) inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for partial  
28 hospitalization through a program that complies with the standards for a partial hospitalization program that  
29 are published by the American association for partial hospitalization if the program is operated by a hospital;  
30 and

~~(e)(iii)~~ inpatient treatment for alcoholism and drug addiction is subject to a maximum benefit of \$4,000 in any 24-month period and a maximum lifetime benefit of \$8,000;

~~(2)(b)~~ under major medical policies or contracts, inpatient benefits and outpatient benefits consisting of durational limits, dollar limits, deductibles, and coinsurance factors that are not less favorable than for physical illness generally, except that:

~~(a)(i)~~ inpatient treatment for mental illness, alcoholism, and drug addiction is subject to a maximum yearly benefit of 21 days;

~~(b)(ii)~~ inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for partial hospitalization through a program that complies with the standards for a partial hospitalization program that are published by the American association for partial hospitalization if the program is operated by a hospital;

~~(e)(iii)~~ inpatient treatment for alcoholism and drug addiction may be subject to a maximum benefit of \$4,000 in any 24-month period and a maximum lifetime benefit of \$8,000;

~~(d)(iv)~~ outpatient treatment for mental illness may be subject to a maximum yearly benefit of no less than \$2,000, but this subsection (4)(1)(b)(iv) does not apply to benefits for services furnished before September 30, 2001, unless the group health plan or group health insurance coverage is exempt from the requirements of subsection (2) pursuant to subsection (3) or (4); and

~~(e)(v)~~ outpatient treatment for alcoholism and drug addiction is subject to a maximum yearly benefit of \$1,000.

(2) A group health plan or group health insurance coverage offered in connection with a group health plan may not impose an aggregate dollar limit on an annual or lifetime basis more restrictively for mental health benefits than for medical and surgical benefits covered by the plans. In the case of a plan that has different aggregate lifetime limits and different annual limits on various categories of medical and surgical benefits, the commissioner shall establish rules for determining a weighted average aggregate lifetime limit and weighted average annual limit to apply to mental health benefits. This subsection does not apply to benefits for services furnished on or after September 30, 2001.

(3) Subsection (2) does not apply to a group health plan or health insurance coverage offered in connection with a group health plan in the small group market.

(4) Subsection (2) does not apply to a group health plan or health insurance coverage offered in connection with a group health plan if the application of subsection (2) results in an increase in the cost under the group health plan or for coverage of at least 3% 1%. This subsection applies separately to each

1 benefit package option in the case of a group health plan that offers a participant or beneficiary two or more  
2 benefit package options under the group health plan."

3  
4 **Section 10.** Section 33-22-1107, MCA, is amended to read:

5 **"33-22-1107. Definitions.** As used in this part, the following definitions apply:

6 (1) "Activities of daily living" means:

7 (a) eating;

8 (b) toileting;

9 (c) transferring;

10 (d) bathing;

11 (e) dressing; and

12 (f) continence.

13 ~~(1)~~(2) "Applicant" means:

14 (a) in the case of an individual long-term care insurance policy, the person who seeks to contract  
15 for ~~the insurance~~ benefits; and

16 (b) in the case of a group long-term care insurance policy, the proposed certificate holder.

17 ~~(2)~~(3) "Appropriate sale criteria" means the set of conditions that an insurance company is required  
18 to address with an applicant that help to determine whether or not a particular insurance policy or contract  
19 offered for sale is appropriate to the applicant. These conditions must include but are not limited to any  
20 insurance premium involved in the policy, the income of the applicant, and the savings and investments  
21 of the applicant.

22 ~~(3)~~(4) "Certificate" means a ~~document~~ certificate ~~issued to a member of the~~ issued to a member of the ~~under a group covered~~  
23 ~~under a group~~ long-term care insurance policy that has been delivered or issued for delivery in this state  
24 ~~as evidence that the individual named in the certificate is covered under the policy.~~

25 ~~(4)~~(5) "Group long-term care insurance" means a long-term care insurance policy that is delivered  
26 or issued for delivery in this state and issued to:

27 (a) (i) an employer;

28 (ii) a labor organization;

29 (iii) a trust established by an employer or labor organization; or

30 (iv) a trustee of a fund established by an employer or labor organization or a combination of

1 employers and labor organizations for:

2 (A) employees or former employees or a combination of employees and former employees; or

3 (B) members or former members of the labor organization or a combination of members and former  
4 members;

5 (b) a professional, trade, or occupational association for its current, former, or retired members or  
6 a combination of current, former, and retired members, if the association:

7 (i) is composed of individuals all of whom are or were actively engaged in the same profession,  
8 trade, or occupation; and

9 (ii) has been maintained in good faith for purposes other than obtaining insurance; or

10 (c) an association, a trust, or the trustee of a fund established, created, or maintained for the  
11 benefit of members of one or more associations.

12 (i) Prior to advertising, marketing, or offering the policy within this state, the association or the  
13 insurer of the association shall file evidence with the commissioner that the association has:

14 (A) a minimum of 100 persons at the outset;

15 (B) been organized and maintained in good faith for purposes other than obtaining insurance;

16 (C) been in active existence for at least 1 year; and

17 (D) a constitution and bylaws requiring that the association hold regular meetings at least annually  
18 to further purposes of the membership; except for credit unions, the association collects dues or solicits  
19 contributions from members; and the members have voting privileges and representation on the governing  
20 board and committees.

21 (ii) Thirty days after filing, the association is considered as having satisfied the organizational  
22 requirements unless the commissioner finds after hearing that the association does not satisfy the  
23 organizational requirements.

24 (d) a group other than as described in subsections ~~(4)(a)~~ (5)(a) through ~~(4)(c)~~ (5)(c) if the  
25 commissioner determines that the:

26 (i) issuance of the group policy is not contrary to the best interests of the public;

27 (ii) issuance of the group policy would result in economies of acquisition or administration; and

28 (iii) benefits are reasonable in relation to the premiums charged.

29 ~~(5)(6)~~ (a) "Long-term care insurance":

30 (i) means a policy ~~as defined in subsection (6)~~ or certificate that is advertised, marketed, offered,

1 or designed to provide coverage for not less than 12 consecutive months for a covered person, on an  
2 expense-incurred, indemnity, prepaid, or other basis, for a necessary or medically necessary diagnostic,  
3 preventive, therapeutic, rehabilitative, or maintenance, or personal care service provided in a setting other  
4 than an acute care unit of a hospital;

5 (ii) ~~includes group and individual insurance policies or riders, whether may be issued by an insurer,~~  
6 fraternal benefit society, health service corporation, prepaid health plan, health maintenance organization,  
7 or similar organization to the extent that it is otherwise authorized to issue life or health insurance;

8 (iii) includes group and individual annuities and life insurance policies or riders that provide directly  
9 or that supplement long-term care insurance; ~~and~~

10 (iv) includes any product advertised, marketed, or offered as long-term care insurance regardless  
11 of any exceptions to the definition included in this section;

12 (v) includes a policy or rider that provides for payment of benefits based upon cognitive impairment  
13 or the loss of functional capacity; and

14 (vi) includes qualified long-term care insurance contracts.

15 (b) Long-term care insurance does not include:

16 (i) an insurance policy that is offered primarily to provide basic medicare supplement coverage,  
17 basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity  
18 coverage, major medical expense coverage, disability income protection coverage, accident-only coverage,  
19 specified disease or specified accident coverage, or limited benefit health coverage; or

20 ~~(e)(ii) Long-term care insurance does not include~~ life insurance policies that accelerate the death  
21 benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring  
22 extraordinary medical intervention, or permanent institutional confinement and that provide the option of  
23 a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits  
24 is conditioned upon the receipt of long-term care.

25 ~~(d)(c)~~ An insurance policy that is offered primarily to provide basic medicare supplement coverage,  
26 basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity  
27 coverage, major medical expense coverage, disability income protection coverage, accident-only coverage,  
28 specified disease or specified accident coverage, or limited benefit health coverage and that also contains  
29 long-term care insurance benefits of a duration of at least 6 months is not required to meet the  
30 requirements of this part unless the premium allocable to the long-term care insurance benefits contained

1 in the policy is greater than 25% of the total policy premium.

2 ~~(6)(7)~~ "Policy" means a policy ~~as defined in 33-15-102, a membership contract as defined in~~  
3 ~~33-20-101, a health care services agreement as defined in 33-31-102, contract, membership contract,~~  
4 ~~health care services agreement, rider, or endorsement~~ delivered or issued for delivery in this state by an  
5 insurer, fraternal benefit society, health service corporation, prepaid health plan, health maintenance  
6 organization, or similar organization.

7 ~~(7)(8)~~ "Preexisting condition" means a condition for which medical advice or treatment was  
8 recommended by or received from a provider of health care services within 6 months preceding the  
9 effective date of coverage of an insured person.

10 (9) "Qualified long-term care insurance contract" means:

11 (a) an individual or group insurance contract that meets the requirement of section 7702B of the  
12 Internal Revenue Code, 26 U.S.C. 7702B, if:

13 (i) the only insurance protection provided under the contract is coverage of qualified long-term care  
14 services;

15 (ii) the contract does not pay or reimburse expenses incurred for services or items to the extent  
16 that the expenses are reimbursable under 42 U.S.C. 1395 or would be reimbursable but for the application  
17 of a deductible or coinsurance amount;

18 (iii) the contract is guaranteed renewable;

19 (iv) the contract does not provide for a cash surrender value or other money that can be paid,  
20 assigned, pledged as collateral for a loan, or borrowed. All refunds of premiums and all policyholder  
21 dividends or similar amounts under the contract are to be applied as a reduction in future premiums or to  
22 increase future benefits. However, a refund of the aggregate premium paid under the contract may be  
23 allowed in the event of death of the insured or a complete surrender or cancellation of the contract.

24 (v) the contract contains the consumer protection provisions set forth in section 7702B(g) of the  
25 Internal Revenue Code, 26 U.S.C. 7702B(g); or

26 (b) a life insurance contract that provides long-term care coverage by rider or as a part of the  
27 contract as long as the contract complies with section 7702B of the Internal Revenue Code, 26 U.S.C.  
28 7702B.

29 (10) (a) "Qualified long-term care services" means necessary diagnostic, preventive, therapeutic,  
30 curing, treating, mitigating, and rehabilitative services and maintenance for personal care services for which

1 an insured is eligible under a qualified long-term care insurance contract and that are provided pursuant to  
2 a plan of care prescribed by a licensed health care practitioner.

3 (b) For the purposes of this subsection (10), "licensed health care practitioner" means any of the  
4 following individuals when licensed in this state:

5 (i) a physician, as defined in 42 U.S.C. 1395x(r)(1);

6 (ii) a registered professional nurse;

7 (iii) a licensed social worker; or

8 (iv) another individual as determined by rules of the commissioner adopted for purposes of  
9 compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

10 (11) "Transferring" means moving into or out of a bed, chair, or wheelchair."

11  
12 **Section 11. Section 33-22-1108, MCA, is amended to read:**

13 **"33-22-1108. Preexisting condition -- definition. (1) A long-term care insurance policy or certificate**  
14 **other than a policy or certificate issued to a group, as ~~defined~~ specified in ~~33-22-1107(3)(a)~~**  
15 **33-22-1107(5)(a)(ii), (5)(a)(iii), or (5)(a)(iv), may not use a definition of preexisting condition ~~which~~ that is**  
16 **more restrictive than the definition in 33-22-1107.**

17 **(2) A long-term care insurance policy or certificate may not exclude coverage for a loss or**  
18 **confinement that is the result of a preexisting condition unless the loss or confinement begins within 6**  
19 **months following the effective date of coverage of an insured person.**

20 **(3) If a long-term care insurance policy or certificate replaces, with similar benefits, another**  
21 **long-term care insurance policy or certificate, the insurer issuing the replacing long-term care insurance**  
22 **policy or certificate shall waive any time periods applicable to preexisting conditions or probationary periods**  
23 **in the replacing long-term care insurance policy or certificate to the extent that similar time periods have**  
24 **been satisfied under the original policy.**

25 **~~(3)(4)~~ (4) The commissioner may extend the limitation periods in subsections (1) and (2) as to specific**  
26 **age group categories in specific policy forms if extending the limitation periods is in the best interests of**  
27 **the public.**

28 **~~(4)(5)~~ (5) An insurer may use an application form designed to elicit the complete health history of an**  
29 **applicant and on the basis of the answers on that application perform underwriting in accordance with the**  
30 **insurer's established underwriting standards. Unless otherwise provided in the long-term care insurance**

policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (2) expires. A long-term care insurance policy or certificate may not exclude or use a waiver or rider of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection (2)."

**Section 12.** Section 33-22-1111, MCA, is amended to read:

**"33-22-1111. Outline of coverage.** (1) (a) An insurer shall deliver an outline of coverage as approved by the commissioner to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(a)(b) The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of the outline of coverage.

(b)(c) In the case of insurance producer solicitations, an insurance producer shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c)(d) In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the earlier of the applicant's request or the delivery of the policy.

(2) The outline of coverage must include:

(a) a description of the principal benefits and coverage provided in the policy;

(b) a statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premiums. Continuation or conversion provisions of a group policy must be specifically described.

(d) a statement that the outline of coverage is only a summary ~~only~~ of the policy issued or applied for, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(e) a description of the terms under which the policy or certificate may be returned and the premium refunded; and

(f) a brief description of the relationship of cost of care and benefits.

(3) The outline of coverage:



- 1        (a) must prominently display the name of the insurer;  
2        (b) must be a freestanding document not dependent for purposes of reader comprehension upon  
3 any other document;  
4        (c) must use no smaller than 12-point type; and  
5        (d) may not contain material of an advertising nature."  
6

7        **Section 13.** Section 33-22-1113, MCA, is amended to read:

8        **"33-22-1113. Disclosure and performance standards for long-term care insurance.** (1) The  
9 commissioner may by rule adopt standards for full and fair disclosure, setting forth the manner, content,  
10 and disclosures required to be made in a long-term care insurance policy, including but not limited to:

- 11        (a) terms of renewability;  
12        (b) initial and subsequent conditions of eligibility;  
13        (c) nonduplication of coverage provisions;  
14        (d) coverage of dependents;  
15        (e) preexisting conditions;  
16        (f) termination of insurance;  
17        (g) continuation or conversion;  
18        (h) probationary periods;  
19        (i) limitations;  
20        (j) exceptions;  
21        (k) reductions;  
22        (l) elimination periods;  
23        (m) requirements for replacement;  
24        (n) recurrent conditions; ~~and~~  
25        (o) definition of terms;  
26        (p) prohibitions on limitations and exclusions;  
27        (q) extension of benefits;  
28        (r) discontinuance and replacement of policies;  
29        (s) unintentional lapse;  
30        (t) prohibitions against postclaim underwriting;

5+

1 (u) minimum standards for home health and community care benefits;

2 (v) inflation protection;

3 (w) incontestability period; and

4 (x) tax consequences.

5 (2) A group long-term care insurance policy must include a provision relating to conversion on  
6 termination of eligibility as described in 33-22-508 or include a provision for continuation of coverage that  
7 maintains coverage under the existing group policy if the coverage would otherwise terminate."  
8

9 **Section 14.** Section 33-22-1114, MCA, is amended to read:

10 **"33-22-1114. Prohibited practices and policy provisions.** (1) An insurance company may not issue  
11 a refund to a person other than the owner of the policy or certificate.

12 (2) A long-term care insurance policy may not:

13 (a) be canceled, nonrenewed, or otherwise terminated on ~~the any grounds of the age or the~~  
14 ~~deterioration of the mental or physical health of an insured or a certificate holder~~ other than the insured's  
15 or certificate holder's failure to pay the premium;

16 (b) contain a provision establishing a new waiting period if existing coverage is converted to or  
17 replaced by a new or other form within the same company, except with respect to an increase in benefits  
18 voluntarily selected by the insured individual or group policyholder; or

19 (c) provide coverage for only skilled nursing care or provide substantially more coverage for skilled  
20 nursing care in a facility than coverage for lower levels of care."  
21

22 **Section 15.** Section 33-22-1115, MCA, is amended to read:

23 **"33-22-1115. Prior hospitalization or institutionalization.** (1) A long-term care insurance policy may  
24 not be delivered or issued for delivery in Montana if the policy conditions eligibility for a benefit:

25 (a) on a prior hospitalization requirement; ~~or~~

26 (b) provided in an institutional care setting on the receipt of a higher level of institutional care; or

27 (c) other than waiver of premium, postconfinement benefits, postacute care benefits, or  
28 recuperative benefits, on a prior institutionalization requirement.

29 (2) A long-term care insurance policy containing a limitation or condition for eligibility other than  
30 those prohibited in subsection (1) must clearly label, in a separate paragraph of the policy or certificate

entitled "Limitations or Conditions on Eligibility for Benefits", the limitations or conditions, including the required number of days of confinement.

(3) A long-term care insurance policy that contains a benefit advertised, marketed, or offered as a home health care benefit may not condition receipt of a benefit on a prior institutionalization requirement.

(4) A long-term care insurance policy that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days for which benefits are paid.

(5) A long-term care insurance policy that provides a benefit only following institutionalization may not condition the benefit upon admission to a facility for the same or a related condition within a period of less than 30 days after discharge from the institution."

**Section 16.** Section 33-22-1121, MCA, is amended to read:

**"33-22-1121. Rules.** The commissioner may adopt rules necessary to implement this part, including but not limited to rules that:

(1) establish loss ratio standards for long-term care insurance policies; ~~and~~

(2) specify the requirements for offering the sale of a policy with nonforfeiture benefits and the types of appropriate sale criteria to be communicated at the time of application;

(3) establish a requirement for the mandatory triggering of policy benefits based upon the number of activities of daily living that an individual is capable or incapable of performing; and

(4) are necessary to implement a determination made by the secretary of health and human services pursuant to Public Law 104-191 as to who is a licensed health care practitioner."

**Section 17.** Section 33-22-1501, MCA, is amended to read:

**"33-22-1501. Definitions.** As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health association created by 33-22-1503.

(2) "Association plan" means a policy of insurance coverage that is offered by the association and that is certified by the association as required by 33-22-1521.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

(4) "Association portability plan" means a policy of insurance coverage that is offered by the

- 1 association to a federally defined eligible individual.
- 2 (5) "Association portability plan premium" means the charge determined by the association and  
3 approved by the commissioner for an association portability plan.
- 4 (6) "Block of business" means a separate risk pool grouping of covered individuals, enrollees, and  
5 dependents as defined by rules of the commissioner.
- 6 ~~(4)~~(7) "Eligible person" means an individual who:
- 7 (a) is a resident of this state and applies for coverage under the association plan;
- 8 (b) unless the individual's eligibility is waived by the association, has, within 6 months prior to the  
9 date of application, been rejected for disability insurance or health service benefits by at least two insurers,  
10 societies, or health service corporations or has had a restrictive rider or preexisting conditions limitation,  
11 which limitation is required by at least two insurers, societies, or health service corporations, which has  
12 the effect of substantially reducing coverage from that received by a person considered a standard risk; and
- 13 (c) is not eligible for any other form of disability insurance or health service benefits.
- 14 (8) "Federally defined eligible individual" means a person who is an individual enrolling in the  
15 association portability plan:
- 16 (a) for whom, as of the date on which the individual seeks coverage under the association  
17 portability plan, the aggregate of the periods of creditable coverage is 18 months or more and whose most  
18 recent prior creditable coverage was under a group health plan, governmental plan, or church plan;
- 19 (b) who does not have other health insurance coverage;
- 20 (c) who is not eligible for coverage under:
- 21 (i) a group health plan;
- 22 (ii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42  
23 U.S.C. 1395j through 1395w-4; or
- 24 (iii) a state plan under Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, or a  
25 successor program;
- 26 (d) for whom the most recent coverage was not terminated for factors relating to nonpayment of  
27 premiums or fraud;
- 28 (e) who, if offered the option of continuation coverage under a COBRA continuation provision or  
29 under a similar state program, elected that coverage; and
- 30 (f) who has exhausted continuation coverage under the COBRA continuation provision or program

described in subsection (8)(e) if the individual elected the continuation coverage described in subsection (8)(e).

~~(6)~~(9) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

~~(6)~~(10) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

~~(7)~~(11) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

~~(8)~~(12) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the association plan.

~~(9)~~(13) "Medicare" means coverage under both parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395, et seq., as amended.

~~(10)~~(14) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 5 years immediately preceding the filing of an application.

~~(11)~~(15) "Society" means a fraternal benefit society operating pursuant to Title 33, chapter 7, and offering or selling certificates of disability insurance."

**Section 18.** Section 33-22-1512, MCA, is amended to read:

**"33-22-1512. Association plan and association portability plan premium.** The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of association plan premiums for eligible persons may not exceed 200% of the average premium rates charged by the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force in this state. The schedule of association portability plan premiums for federally defined eligible individuals may not, for the period of 1 year from [the effective date of this section], be less than 135% and may not at any time exceed 150% of the average premium rates charged by the five insurers or health service corporations with the largest premium amount of

1 individual plans of major medical insurance in force in this state. The premium rates of the five insurers  
2 or health service corporations used to establish the premium rates for each type of coverage offered by the  
3 association must be determined by the commissioner from information provided annually at the request of  
4 the commissioner. The association shall use generally acceptable actuarial principles and structurally  
5 compatible rates."

6

7 **Section 19.** Section 33-22-1513, MCA, is amended to read:

8 **"33-22-1513. Operation of association plan and association portability plans.** (1) Upon acceptance  
9 by the lead carrier under 33-22-1516, an eligible person may enroll in the association plan by payment of  
10 the association plan premium to the lead carrier.

11 (2) Upon application by a federally defined eligible individual to the lead carrier for an association  
12 portability plan, the association may not:

13 (a) decline to offer an association portability plan; or

14 (b) impose a preexisting condition exclusion with respect to an individual's association portability  
15 plan coverage if application for association portability plan coverage is made within 63 days following  
16 termination of the applicant's most recent prior creditable coverage.

17 ~~(2)(3)~~ Not less than 88% of the association plan premiums paid to the lead carrier may be used  
18 to pay claims and not more than 12% may be used for payment of the lead carrier's direct and indirect  
19 expenses as specified in 33-22-1514.

20 ~~(3)(4)~~ Any income in excess of the costs incurred by the association in providing reinsurance or  
21 administrative services must be held at interest and used by the association to offset past and future losses  
22 due to claims expenses of the association plan and the association portability plan or be allocated to reduce  
23 association plan premiums.

24 ~~(4)(5)~~ (a) Each participating member of the association shall share the losses due to claims  
25 expenses of the association plan and the association portability plan for plans issued or approved for  
26 issuance by the association and shall share in the operating and administrative expenses incurred or  
27 estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the  
28 association plan and the association portability plan that exceed the premium payments allocated to the  
29 payment of benefits are the liability of the association members. Association members shall share in the  
30 claims expenses of the association plan and the association portability plan and operating and administrative

1 expenses of the association in an amount equal to the ratio of the association member's total disability  
2 insurance premium received from or on behalf of Montana residents divided by the total disability insurance  
3 premium received by all association members from or on behalf of Montana residents as determined by the  
4 commissioner.

5 (b) For purposes of this subsection ~~(4)~~ (5), "total disability insurance premium" does not include  
6 premiums received from disability income insurance, credit disability insurance, disability waiver insurance,  
7 or life insurance.

8 ~~(5)(6)~~ The association shall make an annual determination of each association member's liability,  
9 if any, and may make an annual fiscal yearend assessment if necessary. Assessments related to the  
10 operation and expenses of the association plan must be determined and levied separately from assessments  
11 related to the operation and expenses of the association portability plan. The association may also, subject  
12 to the approval of the commissioner, provide for interim assessments against the association members as  
13 may be necessary to ~~assure~~ ensure the financial capability of the association in meeting the incurred or  
14 estimated claims expenses of the association plan and the association portability plan and operating and  
15 administrative expenses of the association until the association's next annual fiscal yearend assessment.  
16 Payment of an assessment is due within 30 days of receipt by an association member of a written notice  
17 of a fiscal yearend or interim assessment. Failure by a contributing member to tender to the association the  
18 assessment within 30 days is grounds for termination of membership. An association member that ceases  
19 to do disability insurance business within the state remains liable for assessments through the calendar year  
20 during which disability insurance business ceased. The association may decline to levy an assessment  
21 against an association member if the assessment, as determined pursuant to this section, would not exceed  
22 \$10.

23 ~~(6)(7)~~ Any annual fiscal yearend or interim assessment relating to the operation and expenses of  
24 the association plan levied against an association member may be offset, in an amount equal to the  
25 assessment paid to the association, against the premium tax payable by that association member pursuant  
26 to 33-2-705 for the year in which the annual fiscal yearend or interim assessment is levied. The insurance  
27 commissioner shall report to the office of budget and program planning, as a part of the information  
28 required by 17-7-111, the total amount of premium tax offset claimed by association members during the  
29 preceding biennium. Assessments relating to the operation and expenses of the association portability plan  
30 and levied against an association member may not be offset against the premium tax payable by that

1 association member."

2

3 Section 20. Section 33-22-1516, MCA, is amended to read:

4 "33-22-1516. Enrollment by eligible person. (1) The association plan must be open for enrollment  
5 by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to  
6 the lead carrier. The certificate must provide:

- 7 (a) the name, address, and age of the applicant and length of the applicant's residence in this state;  
8 (b) the name, address, and age of spouse and children, if any, if they are to be insured;  
9 (c) written evidence that the person fulfills all of the elements of an eligible person, as defined in  
10 33-22-1501; and  
11 (d) a designation of coverage desired.

12 (2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application  
13 for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of  
14 acceptance and billing information. Insurance is effective on the first of the month following acceptance.

15 (3) An eligible person may not purchase more than one policy from the association plan.

16 (4) A person who obtains coverage ~~pursuant to this section~~ under the association plan may not  
17 be covered for any preexisting condition during the first 12 months of coverage under the association plan  
18 if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing  
19 of an application. The association may not apply a preexisting condition exclusion to coverage under the  
20 association portability plan if application for association portability plan coverage is made within 63 days  
21 following termination of the applicant's most recent prior creditable coverage. The association shall waive  
22 any time period applicable to a preexisting condition exclusion for the period of time that ~~an~~ any other  
23 eligible individual was covered under the following types of coverage if the coverage was continuous to  
24 a date not more than 30 days prior to submission of an application for coverage under the association plan:  
25 (a) an individual health insurance policy that includes coverage by an insurance company, a  
26 fraternal benefit society, a health service corporation, or a health maintenance organization that provides  
27 benefits similar to or exceeding the benefits provided by the association plan; or  
28 (b) an employer-based health insurance benefit arrangement that provides benefits similar to or  
29 exceeding the benefits provided by the association plan."  
30



1           **Section 21.** Section 33-22-1803, MCA, is amended to read:

2           **"33-22-1803. Definitions.** As used in this part, the following definitions apply:

3           (1) "Actuarial certification" means a written statement by a member of the American academy of  
4 actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance  
5 with the provisions of 33-22-1809, based upon the person's examination, including a review of the  
6 appropriate records and of the actuarial assumptions and methods used by the small employer carrier in  
7 establishing premium rates for applicable health benefit plans.

8           (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or  
9 more intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

10          (3) "Assessable carrier" means all carriers of disability insurance, including excess of loss and stop  
11 loss disability insurance.

12          (4) "Base premium rate" means, for each class of business as to a rating period, the lowest  
13 premium rate charged or that could have been charged under the rating system for that class of business  
14 by the small employer carrier to small employers with similar case characteristics for health benefit plans  
15 with the same or similar coverage.

16          (5) "Basic health benefit plan" means a health benefit plan, except a uniform health benefit plan,  
17 developed by a small employer carrier, that has a lower benefit value than the small employer carrier's  
18 standard benefit plan and that provides the benefits required by 33-22-1827.

19          ~~(6) "Benefit equivalency" means a method developed by the small employer carrier for comparing~~  
20 ~~the types of health care services and articles covered under a health benefit plan with the types of health~~  
21 ~~care services required to be covered under a uniform, basic, or standard health benefit plan.~~

22          (7)(6) "Benefit value" means ~~an actuarially based method developed by the small employer carrier~~  
23 ~~for comparing the value of determinable contingencies covered under a health benefit plan with the value~~  
24 ~~of determinable contingencies required under a uniform, basic, or standard health benefit plan.~~ a numerical  
25 value based on the expected dollar value of benefits payable to an insured under a health benefit plan. The  
26 benefit value must be calculated by the small employer carrier using an actuarially based method and must  
27 take into account all health care expenses covered by the health benefit plan and all cost-sharing features  
28 of the health benefit plan, including deductibles, coinsurance, copayments, and the insured individual's  
29 maximum out-of-pocket expenses. The benefit value must apply equally to indemnity-type health benefit  
30 plans and to managed care health benefit plans, including health maintenance organization-type plans.

~~(8)~~(7) "Board" means the board of directors of the program established pursuant to 33-22-1818.

(8) "Bona fide association" means an association that:

(a) has been actively in existence for at least 5 years;

(b) was formed and has been maintained in good faith for purposes other than obtaining insurance;

(c) does not condition membership in the association on a health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee;

(d) makes health insurance coverage offered through the association available to a member regardless of a health status-related factor relating to the member or an individual eligible for coverage through a member;

(e) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(f) meets any additional requirements required by law.

(9) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit society, a health service corporation, and a health maintenance organization. For purposes of this part, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

(a) an insurance company or health service corporation that is an affiliate of a health maintenance organization located in this state;

(b) a health maintenance organization located in this state that is an affiliate of an insurance company or health service corporation; or

(c) a health maintenance organization that operates only one health maintenance organization in an established geographic service area of this state.

(10) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that gender, claims experience, health status, and duration of coverage are not case characteristics for purposes of this part.

(11) "Class of business" means all or a separate grouping of small employers established pursuant to 33-22-1808.

(12) "Dependent" means:

1 (a) a spouse or an unmarried child under 19 years of age;

2 (b) an unmarried child, under 23 years of age, who is a full-time student and who is financially  
3 dependent on the insured;

4 (c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506  
5 and 33-30-1003; or

6 (d) any other individual defined as a dependent in the health benefit plan covering the employee.

7 (13) "Eligible employee" means an employee who works on a full-time basis with a normal  
8 workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include  
9 an employee who works on a full-time basis with a normal workweek of between 20 and 40 hours as long  
10 as this eligibility criteria is applied uniformly among all of the employer's employees. The term includes a  
11 sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or  
12 independent contractor is included as an employee under a health benefit plan of a small employer. The  
13 term does not include an employee who works on a part-time, temporary, or substitute basis.

14 (14) "Established geographic service area" means a geographic area, as approved by the  
15 commissioner and based on the carrier's certificate of authority to transact insurance in this state, within  
16 which the carrier is authorized to provide coverage.

17 (15) "Health benefit plan" means any hospital or medical policy or certificate providing for physical  
18 and mental health care issued by an insurance company, a fraternal benefit society, or a health service  
19 corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does  
20 not include:

21 ~~(a) accident only, credit, dental, vision, specified disease, medicare supplement, long-term care,~~  
22 ~~or disability income insurance;~~

23 ~~(b) coverage issued as a supplement to liability insurance, workers' compensation insurance, or~~  
24 ~~similar insurance; or~~

25 ~~(c) automobile medical payment insurance~~ coverage of excepted benefits if coverage is provided  
26 under a separate policy, certificate, or contract of insurance.

27 (16) "Index rate" means, for each class of business for a rating period for small employers with  
28 similar case characteristics, the average of the applicable base premium rate and the corresponding highest  
29 premium rate.

30 ~~(17) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health~~

1 ~~benefit plan of a small employer following the initial enrollment period during which the individual was~~  
2 ~~entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period was~~  
3 ~~a period of at least 30 days. However, an eligible employee or dependent may not be considered a late~~  
4 ~~enrollee if:~~

5 ~~(a) the individual requests enrollment within 30 days after termination of the qualifying previous~~  
6 ~~coverage and;~~

7 ~~(i) the individual was covered under qualifying previous coverage at the time of the initial~~  
8 ~~enrollment; or~~

9 ~~(ii) the individual lost coverage under qualifying previous coverage as a result of termination of~~  
10 ~~employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a~~  
11 ~~spouse, or divorce;~~

12 ~~(b) the individual is employed by an employer that offers multiple health benefit plans and the~~  
13 ~~individual elects a different plan during an open enrollment period; or~~

14 ~~(c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under~~  
15 ~~a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance~~  
16 ~~of the court order.~~

17 ~~(17)~~ (17) "New business premium rate" means, for each class of business for a rating period, the  
18 lowest premium rate charged or offered or that could have been charged or offered by the small employer  
19 carrier to small employers with similar case characteristics for newly issued health benefit plans with the  
20 same or similar coverage.

21 ~~(18)~~ (18) "Plan of operation" means the operation of the program established pursuant to  
22 33-22-1818.

23 ~~(19)~~ (19) "Premium" means all money paid by a small employer and eligible employees as a condition  
24 of receiving coverage from a small employer carrier, including any fees or other contributions associated  
25 with the health benefit plan.

26 ~~(20)~~ (20) "Program" means the Montana small employer health reinsurance program created by  
27 33-22-1818.

28 ~~(22) "Qualifying previous coverage" means benefits or coverage provided under:~~

29 ~~(a) medicare or medicaid;~~

30 ~~(b) an employer-based health insurance or health benefit arrangement that provides benefits similar~~

1 ~~to or exceeding benefits provided under the minimum basic health benefit plan; or~~

2 ~~(c) an individual health insurance policy, including coverage issued by an insurance company, a~~  
 3 ~~fraternal benefit society, a health service corporation, or a health maintenance organization that provides~~  
 4 ~~benefits similar to or exceeding the benefits provided under the minimum basic health benefit plan, provided~~  
 5 ~~that the policy has been in effect for a period of at least 1 year.~~

6 ~~(23)(21)~~ "Rating period" means the calendar period for which premium rates established by a small  
 7 employer carrier are assumed to be in effect.

8 ~~(24)(22)~~ "Reinsuring carrier" means a small employer carrier participating in the reinsurance program  
 9 pursuant to 33-22-1819.

10 ~~(25)(23)~~ "Restricted network provision" means a provision of a health benefit plan that conditions  
 11 the payment of benefits, in whole or in part, on the use of health care providers that have entered into a  
 12 contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31,  
 13 to provide health care services to covered individuals.

14 ~~(26)(24)~~ "Small employer" means a person, firm, corporation, partnership, or bona fide association  
 15 that is actively engaged in business and that, ~~on at least 50% of its working days during the preceding~~  
 16 ~~calendar quarter~~ WITH RESPECT TO A CALENDAR YEAR AND A PLAN YEAR, employed at least ~~3~~ 2 but  
 17 not more than ~~25~~ 50 eligible employees, ~~the majority of whom were employed within this state or were~~  
 18 ~~residents of this state~~ DURING THE PRECEDING CALENDAR YEAR AND EMPLOYED AT LEAST TWO  
 19 EMPLOYEES ON THE FIRST DAY OF THE PLAN YEAR. IN THE CASE OF AN EMPLOYER THAT WAS NOT  
 20 IN EXISTENCE THROUGHOUT THE PRECEDING CALENDAR YEAR, THE DETERMINATION OF WHETHER  
 21 THE EMPLOYER IS A SMALL OR LARGE EMPLOYER MUST BE BASED ON THE AVERAGE NUMBER OF  
 22 EMPLOYEES REASONABLY EXPECTED TO BE EMPLOYED BY THE EMPLOYER IN THE CURRENT  
 23 CALENDAR YEAR. In determining the number of eligible employees, companies are considered one  
 24 employer if they:

25 (a) are affiliated companies;

26 (b) are eligible to file a combined tax return for purposes of state taxation; or

27 (c) are members of ~~an~~ a bona fide association that:

28 ~~(i) has have been actively in existence for 1 year prior to January 1, 1994 at least 5 years;~~

29 ~~(ii) have been formed and maintained in good faith for purposes other than obtaining insurance;~~

30 ~~(iii) do not condition membership in the bona fide association on any health status-related factor~~

1 ~~relating to an individual;~~

2 ~~(iv) do not make health insurance coverage offered through the bona fide association available~~  
3 ~~other than in connection with a member of the bona fide association;~~

4 ~~(v) provides provide a health benefit plan to employees of its members as a group; and~~

5 ~~(iii)(vi) does do not deny coverage to any small employer member of its bona fide association or~~  
6 ~~any employee of its small employer members who applies for coverage as part of a group.~~

7 ~~(27)(25)~~ "Small employer carrier" means a carrier that offers health benefit plans that cover eligible  
8 employees of one or more small employers in this state.

9 ~~(28)(26)~~ "Standard health benefit plan" means a health benefit plan that is developed by a small  
10 employer carrier and that contains the provisions required pursuant to 33-22-1828."

11

12 **Section 22.** Section 33-22-1804, MCA, is amended to read:

13 **"33-22-1804. Applicability and scope.** (1) This part applies to a health benefit plan marketed  
14 through a small employer that provides coverage to the employees of a small employer in this state if any  
15 of the following conditions are met:

16 (a) a portion of the premium or benefits is paid by or on behalf of the small employer;

17 (b) an eligible employee or dependent is reimbursed, whether through wage adjustments or  
18 otherwise, by or on behalf of the small employer for any portion of the premium; ~~or~~

19 (c) the health benefit plan is treated by the employer or any of the eligible employees or dependents  
20 as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code,  
21 except a plan or program that is funded entirely by contributions from the employees; or

22 (d) all of the premium is paid by the employee who obtains coverage through the employer's group  
23 health benefit plan.

24 ~~(2) A payroll deduction or a list-billed premium is not a reimbursement for the purposes of~~  
25 ~~subsection (1)(b). This part does not apply to an individual health benefit plan for which the entire premium~~  
26 ~~is paid by an employee through payroll deduction or other means.~~

27 (3) This part applies to an individual health benefit plan if the eligible employee or dependent is  
28 directly or indirectly reimbursed, whether through wage adjustments or otherwise, by or on behalf of the  
29 small employer for any portion of the premium."

30

1           **Section 23.** Section 33-22-1809, MCA, is amended to read:

2           **"33-22-1809. Restrictions relating to premium rates.** (1) Premium rates for health benefit plans  
3 under this part are subject to the following provisions:

4           (a) The index rate for a rating period for any class of business may not exceed the index rate for  
5 any other class of business by more than 20%.

6           (b) For each class of business, the premium rates charged during a rating period to small employers  
7 with similar case characteristics for the same or similar coverage or the rates that could be charged to the  
8 employer under the rating system for that class of business may not vary from the index rate by more than  
9 25% of the index rate.

10           (c) The percentage increase in the premium rate charged to a small employer for a new rating  
11 period may not exceed the sum of the following:

12           (i) the percentage change in the new business premium rate measured from the first day of the  
13 prior rating period to the first day of the new rating period; in the case of a health benefit plan into which  
14 the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use  
15 the percentage change in the base premium rate, provided that the change does not exceed, on a  
16 percentage basis, the change in the new business premium rate for the most similar health benefit plan into  
17 which the small employer carrier is actively enrolling new small employers;

18           (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less  
19 than 1 year, because of the claims experience, health status, or duration of coverage of the employees or  
20 dependents of the small employer, as determined from the small employer carrier's rate manual for the class  
21 of business; and

22           (iii) any adjustment because of a change in coverage or a change in the case characteristics of the  
23 small employer, as determined from the small employer carrier's rate manual for the class of business.

24           (d) Adjustments in rates for claims experience, health status, and duration of coverage may not  
25 be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates  
26 charged for all employees and dependents of the small employer.

27           (e) If a small employer carrier uses industry as a case characteristic in establishing premium rates,  
28 the rate factor associated with any industry classification may not vary from the average of the rate factors  
29 associated with all industry classifications by more than 15% of that coverage.

30           (f) In the case of health benefit plans delivered or issued for delivery prior to January 1, 1994, a

1 premium rate for a rating period may exceed the ranges set forth in subsections (1)(a) and (1)(b) until  
2 January 1, 1997. In that case, the percentage increase in the premium rate charged to a small employer  
3 for a new rating period may not exceed the sum of the following:

4 (i) the percentage change in the new business premium rate measured from the first day of the  
5 prior rating period to the first day of the new rating period; in the case of a health benefit plan into which  
6 the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use  
7 the percentage change in the base premium rate, provided that the change does not exceed, on a  
8 percentage basis, the change in the new business premium rate for the most similar health benefit plan into  
9 which the small employer carrier is actively enrolling new small employers; and

10 (ii) any adjustment because of a change in coverage or a change in the case characteristics of the  
11 small employer, as determined from the small employer carrier's rate manual for the class of business.

12 (g) A small employer carrier shall:

13 (i) apply rating factors, including case characteristics, consistently with respect to all small  
14 employers in a class of business. Rating factors must produce premiums for identical groups that differ only  
15 by the amounts attributable to plan design and that do not reflect differences because of the nature of the  
16 groups. Differences among base premium rates may not be based in any way on the actual or expected  
17 health status or claims experience of the small employer groups that choose or are expected to choose a  
18 particular health benefit plan.

19 (ii) treat all health benefit plans issued or renewed in the same calendar month as having the same  
20 rating period.

21 (h) For the purposes of this subsection (1), a health benefit plan that includes a restricted network  
22 provision may not be considered similar coverage to a health benefit plan that does not include a restricted  
23 network provision.

24 (2) A small employer carrier may not transfer a small employer involuntarily into or out of a class  
25 of business. A small employer carrier may not offer to transfer a small employer into or out of a class of  
26 business unless the offer is made to transfer all small employers in the class of business without regard to  
27 case characteristics, claims experience, health status, or duration of coverage since the insurance was  
28 issued.

29 (3) The commissioner may suspend for a specified period the application of subsection (1)(a) for  
30 the premium rates applicable to one or more small employers included within a class of business of a small



1 employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by  
2 the commissioner either that the suspension is reasonable in light of the financial condition of the small  
3 employer carrier or that the suspension would enhance the fairness and efficiency of the small employer  
4 health insurance market.

5 (4) In connection with the offering for sale of any health benefit plan to a small employer, a small  
6 employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of each  
7 of the following:

8 (a) the extent to which premium rates for a specified small employer are established or adjusted  
9 based upon the actual or expected variation in claims costs or upon the actual or expected variation in  
10 health status of the employees of small employers and the employees' dependents;

11 (b) the provisions of the health benefit plan concerning the small employer carrier's right to change  
12 premium rates and the factors, other than claims experience, that affect changes in premium rates;

13 (c) the provisions relating to renewability of policies and contracts; and

14 (d) the provisions relating to any preexisting condition.

15 (5) (a) Each small employer carrier shall maintain at its principal place of business a complete and  
16 detailed description of its rating practices and renewal underwriting practices, including information and  
17 documentation that demonstrate that its rating methods and practices are based upon commonly accepted  
18 actuarial assumptions and are in accordance with sound actuarial principles.

19 (b) Each small employer carrier shall file with the commissioner annually, on or before March 15,  
20 an actuarial certification certifying that the carrier is in compliance with this part and that the rating  
21 methods of the small employer carrier are actuarially sound. The actuarial certification must be in a form  
22 and manner and must contain information as specified by the commissioner. A copy of the actuarial  
23 certification must be retained by the small employer carrier at its principal place of business.

24 (c) The filing required in subsection (5)(b) must contain the small employer carrier's ~~benefit~~  
25 ~~equivalency and~~ benefit value.

26 (d) A small employer carrier shall make the information and documentation described in subsection  
27 (5)(a) available to the commissioner upon request. Except in cases of violations of the provisions of this  
28 part and except as agreed to by the small employer carrier or as ordered by a court of competent  
29 jurisdiction, the information must be considered proprietary and trade secret information and is not subject  
30 to disclosure by the commissioner to persons outside of the department.

1 (6) The commissioner may not require prior approval of the rating methods used by small employer  
2 carriers or the premium rates of the health benefit plans offered to small employers."  
3

4 **Section 24.** Section 33-22-1811, MCA, is amended to read:

5 **"33-22-1811. Availability of coverage -- required plans.** (1) (a) As a condition of transacting  
6 business in this state with small employers, each small employer carrier ~~shall offer to small employers~~ must  
7 have approved for issuance to small employer groups at least two health benefit plans. One plan must be  
8 a basic health benefit plan, and one plan must be a standard health benefit plan.

9 (b) (i) A small employer carrier shall issue a basic health benefit plan or a standard health benefit  
10 plan to any eligible small employer that applies for ~~either a~~ EITHER plan and agrees to make the required  
11 premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent  
12 with this part. IF, PURSUANT TO PUBLIC LAW 104-191, AN AGENCY OF THE UNITED STATES OR A  
13 COURT DOES NOT PROHIBIT A SMALL EMPLOYER CARRIER FROM DOING SO, A SMALL EMPLOYER  
14 CARRIER MAY OFFER AND ISSUE A GROUP HEALTH BENEFIT PLAN OTHER THAN A BASIC OR  
15 STANDARD PLAN ON AN UNDERWRITTEN BASIS.

16 (ii) In the case of a small employer carrier that establishes more than one class of business pursuant  
17 to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one  
18 basic health benefit plan and at least one standard health benefit plan in each established class of business.  
19 A small employer carrier may apply reasonable criteria in determining whether to accept a small employer  
20 into a class of business, provided that:

21 (A) the criteria are not intended to discourage or prevent acceptance of small employers applying  
22 for a ~~basic or standard~~ health benefit plan;

23 (B) the criteria are not related to the health status or claims experience of the small employers'  
24 employees;

25 (C) the criteria are applied consistently to all small employers that apply for coverage in that class  
26 of business; and

27 (D) the small employer carrier provides for the acceptance of all eligible small employers into one  
28 or more classes of business.

29 (iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the  
30 small employer carrier is no longer enrolling new small businesses.

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(c) A small employer carrier that elects not to comply with the requirements of subsections (1)(a) and (1)(b) may continue to provide coverage under health benefit plans previously issued to small employers in this state for a period of no more than 7 years from October 1, 1995, if the carrier:

(i) complies with all other applicable provisions of this part, except 33-22-1810, 33-22-1813, and subsections (2) through (4) of this section; and

(ii) does not amend or alter the benefits and coverages of the previously issued health benefit plans unless required to do so by law or rule.

(2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and the standard health benefit plans to be used by the small employer carrier.

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this part.

(3) Health benefit plans covering small employers must comply with the following provisions:

(a) A health benefit plan may not:

(i) because of a preexisting condition, deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage. A health benefit plan may not define a preexisting condition exclusion more restrictively than ~~33-22-110(2)~~ [section 34 33].

(ii) use a preexisting condition exclusion more restrictive than exclusions allowed under [section 40 39].

(b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time that an individual was previously covered by ~~qualifying previous~~ creditable coverage that provided benefits with respect to those services if the ~~qualifying previous~~ creditable coverage was continuous to a date not more than ~~30 63~~ days prior to the submission of an application for new coverage. This subsection (3)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date the individual enrolls for coverage under the health benefit plan.

(d) (i) Requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

(ii) A small employer carrier may vary the application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subsection (3)(c).

(ii) A small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(iii) A small employer carrier shall secure a waiver of coverage from each eligible employee who declines, at the sole discretion of the eligible employee, an offer of coverage under a health benefit plan provided by the small employer. The waiver must be signed by the eligible employee and must certify that the employee was informed of the availability of coverage under the health benefit plan and of the penalties for late enrollment. The waiver may not require the eligible employee to disclose the reasons for declining coverage.

(iv) A small employer carrier may not issue coverage to a small employer if the carrier or a producer for the carrier has evidence that the small employer induced or pressured an eligible employee to decline coverage due to the health status or risk characteristics of the eligible employee or of the dependents of the eligible employee.

(4) (a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) ~~to a small employer when the small employer is not physically located in the carrier's established geographic service area;~~

(iii) ~~to an employee when the employee does~~ employer whose employees do not work or reside within the small employer carrier's established geographic service area for a network plan, as defined in

1 [section 34 33]; or

2 ~~(iii)(ii)~~ within an area where the small employer carrier reasonably anticipates and demonstrates to  
3 the satisfaction of the commissioner that it will not have the capacity within its established geographic  
4 service area to deliver service adequately to the members of a group because of its obligations to existing  
5 group policyholders and enrollees. The small employer carrier may not deny coverage under this subsection  
6 unless the small employer carrier acts uniformly without regard to claims experience or health status-related  
7 factors of employers, employees, or dependents.

8 (b) A small employer carrier may not be required to provide coverage to small employers pursuant  
9 to subsection (1) ~~for any period of time for which the commissioner determines that requiring the~~  
10 ~~acceptance of small employers in accordance with the provisions of subsection (1) would place the small~~  
11 ~~employer carrier in a financially impaired condition~~ the small employer carrier does not have the financial  
12 reserves necessary to underwrite additional coverage and that the small employer carrier has denied  
13 coverage of small employers uniformly throughout the state and without regard to the claims experience  
14 and health status-related factors of the applicant small employer groups. The small employer carrier  
15 exempted from providing coverage under this subsection may not offer coverage to small employer groups  
16 in this state for 180 days after the date on which coverage is denied or until the small employer carrier has  
17 demonstrated to the commissioner that the small employer carrier has sufficient financial reserves to  
18 underwrite additional coverage, whichever is later."

19  
20 **Section 25.** Section 33-22-1819, MCA, is amended to read:

21 **"33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation. (1)**  
22 Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a  
23 plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the  
24 fair, reasonable, and equitable administration of the program. The commissioner may, after notice and  
25 hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair,  
26 reasonable, and equitable administration of the program and if the plan of operation provides for the sharing  
27 of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this  
28 section. The plan of operation is effective upon written approval by the commissioner.

29 (2) If the board fails to submit a suitable plan of operation within 180 days after its appointment,  
30 the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The

1 commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan  
2 of operation is submitted by the board and approved by the commissioner.

3 (3) The plan of operation must:

4 (a) establish procedures for the handling and accounting of program assets and money and for an  
5 annual fiscal reporting to the commissioner;

6 (b) establish procedures for selecting an administering carrier and setting forth the powers and  
7 duties of the administering carrier;

8 (c) establish procedures for reinsuring risks in accordance with the provisions of this section;

9 (d) establish procedures for collecting assessments from assessable carriers to fund claims incurred  
10 by the program;

11 (e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to  
12 fund administrative expenses incurred or to be incurred by the program; and

13 (f) provide for any additional matters necessary for the implementation and administration of the  
14 program.

15 (4) The program has the general powers and authority granted under the laws of this state to  
16 insurance companies and health maintenance organizations licensed to transact business, except the power  
17 to issue health benefit plans directly to either groups or individuals. In addition, the program may:

18 (a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this  
19 part, including the authority, with the approval of the commissioner, to enter into contracts with similar  
20 programs of other states for the joint performance of common functions or with persons or other  
21 organizations for the performance of administrative functions;

22 (b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums  
23 and penalties for, on behalf of, or against the program or any reinsuring carriers;

24 (c) take any legal action necessary to avoid the payment of improper claims against the program;

25 (d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance  
26 policies in accordance with the requirements of this part;

27 (e) establish conditions and procedures for reinsuring risks under the program;

28 (f) establish actuarial functions as appropriate for the operation of the program;

29 (g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical  
30 assistance in operation of the program, policy and other contract design, and any other function within the

1 authority of the program;

2 (h) to the extent permitted by federal law and in accordance with subsection (8)(c), make annual  
3 assessments against assessable carriers and make interim assessments to fund claims incurred by the  
4 program; and

5 (i) borrow money to effect the purposes of the program. Any notes or other evidence of  
6 indebtedness of the program not in default are legal investments for carriers and may be carried as admitted  
7 assets.

8 (5) A reinsuring carrier may reinsure with the program as provided for in this subsection (5):

9 (a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall  
10 reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to  
11 the level of coverage provided in a basic or standard health benefit plan.

12 (b) A small employer carrier may reinsure an entire employer group within 60 days of the  
13 commencement of the group's coverage under a health benefit plan.

14 (c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days  
15 following the commencement of coverage with the small employer. A newly eligible employee or dependent  
16 of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

17 (d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured  
18 employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent  
19 of \$5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is  
20 responsible for 20% of the next \$100,000 of benefit payments during a calendar year and the program  
21 shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a  
22 maximum limit of \$25,000 in any calendar year with respect to any reinsured individual.

23 (ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by  
24 the carrier to reflect increases in costs and utilization within the standard market for health benefit plans  
25 within the state. The adjustment may not be less than the annual change in the medical component of the  
26 consumer price index for all urban consumers of the United States department of labor, bureau of labor  
27 statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

28 (e) A small employer carrier may terminate reinsurance with the program for one or more of the  
29 reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

30 (f) A small employer group health benefit plan in effect before January 1, 1994, may not be

1 reinsured by the program until January 1, 1997, and then only if the board determines that sufficient  
2 funding sources are available.

3 (g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including  
4 utilization review, individual case management, preferred provider provisions, and other managed care  
5 provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

6 (6) (a) As part of the plan of operation, the board shall establish a methodology for determining  
7 premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this  
8 section. The methodology must include a system for classification of small employers that reflects the types  
9 of case characteristics commonly used by small employer carriers in the state. The methodology must  
10 provide for the development of base reinsurance premium rates that must be multiplied by the factors set  
11 forth in subsection (6)(b) to determine the premium rates for the program. The base reinsurance premium  
12 rates must be established by the board, subject to the approval of the commissioner, and must be set at  
13 levels that reasonably approximate the premiums necessary to recover one-half of the expenses for the  
14 calendar year. For purposes of this section, expenses include administrative expenses, ~~one-half of the~~  
15 ~~program net loss for the previous calendar year,~~ and the actuarially anticipated claims to be incurred,  
16 adjusted to reflect retention levels required under this part.

17 (b) Premiums for the program are as follows:

18 (i) An entire small employer group may be reinsured for a rate that is one and one-half times the  
19 base reinsurance premium rate for the group established pursuant to this subsection (6).

20 (ii) An eligible employee or dependent may be reinsured for a rate that is five times the base  
21 reinsurance premium rate for the individual established pursuant to this subsection (6).

22 (c) The board shall annually review the methodology established under subsection (6)(a), including  
23 the system of classification and any rating factors, to ensure that it is actuarially sound and that it  
24 reasonably reflects the claims experience of the program. The board may propose changes to the  
25 methodology that are subject to the approval of the commissioner.

26 (d) The board may consider adjustments to the premium rates charged by the program to reflect  
27 the use of effective cost containment and managed care arrangements.

28 (7) If a health benefit plan for a small employer is entirely or partially reinsured with the program,  
29 the premium charged to the small employer for any rating period for the coverage issued must meet the  
30 requirements relating to premium rates set forth in 33-22-1809.

52



7

(8) (a) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses, and the actuarially anticipated losses for the calendar year. The sum of ~~one-half of the program net loss for the previous calendar year plus one-half of the actuarially anticipated net loss for the calendar year~~ claims to be incurred during the current calendar year and one-half of anticipated administrative expenses during the current calendar year must equal the total assessment amount. ~~If the program net loss for the previous calendar year is zero or less, the total assessment amount must equal the actuarially anticipated losses for the calendar year.~~

(b) (i) Each assessable carrier shall share in the program in an amount determined by multiplying the total assessment amount by a fraction, the numerator of which is the number of individuals in this state covered under disability insurance by the assessable carrier and the denominator of which is the number of all individuals in this state covered under disability insurance by all assessable carriers.

(ii) The board shall make a reasonable effort to ensure that each insured individual is counted only once for the purpose of assessment. The board shall require each assessable carrier that provides excess of loss or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured in whole or in part, including coverage under excess of loss or stop loss insurance. The board shall allow an assessable carrier who is an excess of loss or stop loss insurer to exclude from its count of insured individuals those who have been counted by a primary disability insurer or by a primary reinsurer.

(iii) The board shall base each assessable carrier's assessment on reports filed with the commissioner as required by ~~33-22-1820~~ 33-2-704. The board may use any reasonable method of estimating the number of individuals insured by an assessable carrier if the specific number is unknown.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the contribution to the program and, except as otherwise provided by this section, make an annual assessment against each assessable carrier to the extent of that liability. Payment of an assessment is due within 30 days of receipt by the assessable carrier of written notice of the assessment. An assessable carrier that ceases doing business within the state is liable for assessments until the end of the calendar year in which the assessable carrier ceased doing business. The board may determine not to assess an assessable carrier if the assessable carrier's liability determined in accordance with this section does not exceed \$10.

1 (d) The board may establish and maintain program reserves not to exceed five times the actuarially  
2 anticipated losses for the calendar year.

3 (e) If the sum of the reinsurance premiums and assessments in any calendar year exceeds the sum  
4 of the administrative expenses and incurred claims for that year, the board may proportionately credit the  
5 excess to assessable carriers or it may place the excess in program reserves, subject to the limits in  
6 subsection (8)(d).

7 (9) The participation in the program as reinsuring carriers; the establishment of rates, forms, or  
8 procedures; or any other joint collective action required by this part may not be the basis of any legal  
9 action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly  
10 or separately.

11 (10) The board, as part of the plan of operation, shall develop standards setting forth the minimum  
12 levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In  
13 establishing the standards, the board shall take into consideration the need to ensure the broad availability  
14 of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need  
15 to provide ongoing service to small employers, the levels of compensation currently used in the industry,  
16 and the overall costs of coverage to small employers selecting these plans.

17 (11) The program is exempt from taxation.

18 (12) On or before March 1 of each year, the commissioner shall evaluate the operation of the  
19 program and report to the governor and the legislature in writing the results of the evaluation. The report  
20 must include an estimate of future costs of the program, assessments necessary to pay those costs, the  
21 appropriateness of premiums charged by the program, the level of insurance retention under the program,  
22 the cost of coverage of small employers, and any recommendations for change to the plan of operation.

23 (13) All premiums and other money paid to the small employer carrier reinsurance program and all  
24 property and securities acquired through the use of money and interest and dividends earned on money  
25 belonging to the small employer carrier reinsurance program are solely the property of the program and  
26 must be used exclusively for the operations and obligations of the program. Money collected by the  
27 program is not subject to legislative appropriation."  
28

29 **Section 26.** Section 33-22-1827, MCA, is amended to read:

30 **"33-22-1827. Benefits required in basic health benefit plan.** (1) The basic health benefit plan must

1 provide at least the following benefits:

2 (a) coverage for the services and articles required by 33-22-1521(2);

3 (b) coverage for mental health and chemical dependency required by Title 33, chapter 22, part 7;

4 and

5 (c) coverage for conversion of benefits required by 33-22-508 and 33-22-510 or by 33-30-1007.

6 (2) The small employer carrier may determine varying levels of deductibles, copayments, maximum  
7 annual out-of-pocket expenses, maximum lifetime benefits, and other financial cost-sharing arrangements  
8 with the insured that give the basic health benefit plan a lower benefit value than the standard health  
9 benefit plan.

10 (3) A basic health benefit plan provided by a health maintenance organization or a basic health  
11 benefit plan with a restricted network provision must provide a comparable level of benefits to those  
12 required by subsections (1) and (2), as determined by the ~~benefit equivalency and~~ benefit value."  
13

14 **Section 27.** Section 33-22-1828, MCA, is amended to read:

15 **"33-22-1828. Benefits required in standard benefit plan.** (1) The minimum benefits must be equal  
16 to at least 75% of the covered expenses in excess of an annual deductible that does not exceed \$500 per  
17 person or \$1,000 per family. The coverage must include a limitation of \$2,000 per person or \$4,000 per  
18 family on the total annual out-of-pocket expenses for services covered. The coverage may be subject to  
19 a maximum lifetime benefit, but a maximum, if any, may not be less than \$1 million.

20 (2) The commissioner may not require coverage in a standard health benefit plan for any benefit  
21 unless other provisions of Title 33, chapter 22, 30, or 31, specifically require coverage for the benefit. A  
22 small employer carrier may offer coverage for additional services and articles.

23 (3) A standard health benefit plan provided by a health maintenance organization or a basic health  
24 benefit plan with a restricted network provision must provide a comparable level of benefits to those  
25 required by subsection (1), as determined by the ~~benefit equivalency and~~ benefit value."  
26

27 **Section 28.** Section 33-30-1001, MCA, is amended to read:

28 **"33-30-1001. Newborn infants covered by insurance by health service corporation.** A disability  
29 insurance plan or group disability insurance plan issued by a health service corporation may not be issued  
30 or amended in this state if it contains any disclaimer, waiver, preexisting condition exclusion, or other

1 limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of  
2 the persons insured from and after the moment of birth. Each policy must contain a provision granting  
3 immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of  
4 any insured person. The policy or contract may require notification of the birth of a child and payment of  
5 a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation  
6 within 31 days of the birth in order to have the coverage extend beyond 31 days."

7

8 **Section 29.** Section 33-31-102, MCA, is amended to read:

9 **"33-31-102. Definitions.** As used in this chapter, unless the context requires otherwise, the  
10 following definitions apply:

11 (1) "Affiliation period" means a period that, under the terms of the health insurance coverage  
12 offered by a health maintenance organization, must expire before the health insurance coverage becomes  
13 effective.

14 (2) "Basic health care services" means:

- 15 (a) consultative, diagnostic, therapeutic, and referral services by a provider;
- 16 (b) inpatient hospital and provider care;
- 17 (c) outpatient medical services;
- 18 (d) medical treatment and referral services;
- 19 (e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant  
20 to 33-31-301(3)(e);
- 21 (f) care and treatment of mental illness, alcoholism, and drug addiction;
- 22 (g) diagnostic laboratory and diagnostic and therapeutic radiologic services;
- 23 (h) preventive health services, including:
  - 24 (i) immunizations;
  - 25 (ii) well-child care from birth;
  - 26 (iii) periodic health evaluations for adults;
  - 27 (iv) voluntary family planning services;
  - 28 (v) infertility services; and
  - 29 (vi) children's eye and ear examinations conducted to determine the need for vision and hearing  
30 correction;

(i) minimum mammography examination, as defined in 33-22-132; and

(j) treatment for phenylketonuria. "Treatment" means licensed professional medical services under the supervision of a physician and a dietary formula product to achieve and maintain normalized blood levels of phenylalanine and adequate nutritional status.

~~(2)~~(3) "Commissioner" means the commissioner of insurance of the state of Montana.

~~(3)~~(4) "Enrollee" means a person:

(a) who enrolls in or contracts with a health maintenance organization;

(b) on whose behalf a contract is made with a health maintenance organization to receive health care services; or

(c) on whose behalf the health maintenance organization contracts to receive health care services.

~~(4)~~(5) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.

~~(5)~~(6) "Health care services" means:

(a) the services included in furnishing medical or dental care to a person;

(b) the services included in hospitalizing a person;

(c) the services incident to furnishing medical or dental care or hospitalization; or

(d) the services included in furnishing to a person other services for the purpose of preventing, alleviating, curing, or healing illness, injury, or physical disability.

~~(6)~~(7) "Health care services agreement" means an agreement for health care services between a health maintenance organization and an enrollee.

~~(7)~~(8) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers.

~~(8)~~(9) "Insurance producer" means an individual, partnership, or corporation appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.

~~(9)~~(10) "Person" means:

(a) an individual;

(b) a group of individuals;

(c) an insurer, as defined in 33-1-201;

(d) a health service corporation, as defined in 33-30-101;

(e) a corporation, partnership, facility, association, or trust; or

(f) an institution of a governmental unit of any state licensed by that state to provide health care, including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

~~(10)~~(11) "Plan" means a health maintenance organization operated by an insurer or health service corporation as an integral part of the corporation and not as a subsidiary.

~~(11)~~(12) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or nurse specialist, as specifically listed in 37-8-202, who treats any illness or injury within the scope and limitations of his practice or any other person who is licensed or otherwise authorized in this state to furnish health care services.

~~(12)~~(13) "Uncovered expenditures" mean the costs of health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes insolvent."

**Section 30.** Section 33-31-111, MCA, is amended to read:

**"33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to any health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives may not be construed as a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter may not be considered to be practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) The provisions of this chapter do not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) The provisions of this section do not exempt a health maintenance organization from material

transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-701 through 33-3-704.

(6) [Sections 35 through 41 and 45 34 THROUGH 40 AND 44] apply to health maintenance organizations."

**Section 31.** ~~Section 33-31-301, MCA, is amended to read:~~

~~"33-31-301. Evidence of coverage — schedule of charges for health care services. (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.~~

~~(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.~~

~~(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:~~

~~(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:~~

~~(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;~~

~~(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;~~

~~(iii) the location at which and the manner in which information is available as to how services may be obtained;~~

~~(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and~~

~~(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;~~

~~(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.~~

~~(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:~~

~~(i) emergency and urgent care;~~

~~(ii) restrictions on the selection of primary or referral providers;~~

~~(iii) restrictions on changing providers during the contract period;~~

~~(iv) out-of-pocket costs, including copayments and deductibles;~~

~~(v) charges for missed appointments or other administrative sanctions;~~

~~(vi) restrictions on access to care if copayments or other charges are not paid; and~~

~~(vii) any restrictions on coverage for dependents who do not reside in the service area.~~

~~(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;~~

~~(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;~~

~~(f) a provision providing coverage as required in [section 62];~~

~~(f)(g) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:~~

~~(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;~~

~~(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the~~



1 ~~scope of the referral in order to receive payment from the health maintenance organization;~~

2 ~~(iii) the amount paid by the health maintenance organization to the enrollee's designated provider,~~  
3 ~~may not exceed the amount paid by the health maintenance organization to one of its providers for~~  
4 ~~equivalent treatment or services;~~

5 ~~(iv) the provisions of this subsection (3)(f) (3)(g) do not apply to services for mental illness provided~~  
6 ~~under the Montana medicaid program as established in Title 53, chapter 6;~~

7 ~~(g)(h) a provision as follows:~~

8 ~~"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective~~  
9 ~~date is in conflict with the statutes of the state in which the insured resides on that date is amended to~~  
10 ~~conform to the minimum requirements of those statutes."~~

11 ~~(h)(i) a provision that the health maintenance organization shall issue, without evidence of~~  
12 ~~insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee,~~  
13 ~~dependents, or family members;~~

14 ~~(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members~~  
15 ~~covered under the evidence of coverage ceases because of termination of employment or termination of~~  
16 ~~membership in the class or classes eligible for coverage under the policy or because the employer~~  
17 ~~discontinues the business or the coverage;~~

18 ~~(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months~~  
19 ~~preceding the termination of group coverage; and~~

20 ~~(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group~~  
21 ~~coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by~~  
22 ~~the group contract from which the enrollee converts.~~

23 ~~(i)(ii) a provision that clearly describes the amount of money an enrollee shall pay to the health~~  
24 ~~maintenance organization to be covered for basic health care services.~~

25 ~~(4) A health maintenance organization may amend an enrollment form or an evidence of coverage~~  
26 ~~in a separate document if the separate document is filed with and approved by the commissioner and issued~~  
27 ~~to the enrollee.~~

28 ~~(5) (a) A health maintenance organization shall provide the same coverage for newborn infants,~~  
29 ~~required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be~~  
30 ~~no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce~~

~~benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.~~

~~(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the moment of birth.~~

~~(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.~~

~~(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee may not be individually determined based on the status of the enrollee's health.~~

~~(7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a hearing within 30 days after receipt of a written request by the filer.~~

~~(8) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."~~

**Section 31.** Section 33-31-322, MCA, is amended to read:

**"33-31-322. Uniform health benefit plan -- health maintenance organization.** Each health maintenance organization delivering or issuing for delivery in this state an enrollment form or evidence of coverage shall make available a uniform health benefit plan providing ~~benefit equivalency and~~ benefit value,

as defined in 33-22-1803, comparable to the uniform health benefit plan required in 33-22-245(2)."

**Section 32.** Section 33-35-306, MCA, is amended to read:

**"33-35-306. Application of insurance code to arrangements.** (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions of Title 33:

(a) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

(b) Title 33, chapter 1, part 7;

(c) 33-3-308; and

(d) Title 33, chapter 18, except 33-18-242; and

(e) [sections 43 and 45 42 AND 44].

(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked."

**NEW SECTION. Section 33. Definitions.** As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Beneficiary" has the meaning given the term by 29 U.S.C. 1002(33).

(2) "Church plan" has the meaning given the term by 29 U.S.C. 1002(33).

(3) "COBRA continuation provision" means:

(a) section 4980B of the Internal Revenue Code, 26 U.S.C. 4980B, other than subsection (f)(1) of that section as it relates to pediatric vaccines;

(b) Title I, subtitle B, part 6, excluding section 609, of the Employee Retirement Income Security Act of 1974, Public Law 93-406; or

(c) Title XXII of the Public Health Service Act, 42 U.S.C. 300dd, et seq.

(4) (a) "Creditable coverage" means coverage of the individual under any of the following:

(i) a group health plan;

(ii) health insurance coverage;

(iii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42

1 U.S.C. 1395j through 1395w-4;

2 (iv) Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage  
3 consisting solely of a benefit under section 1928, 42 U.S.C. 1396s;

4 (v) Title 10, chapter 55, United States Code;

5 (vi) a medical care program of the Indian health service or of a tribal organization;

6 (vii) the Montana comprehensive health association provided for in 33-22-1503;

7 (viii) a health plan offered under Title 5, chapter 89, of the United States Code;

8 (ix) a public health plan;

9 (x) a health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).

10 (b) Creditable coverage does not include coverage consisting solely of coverage of excepted  
11 benefits.

12 (5) "Elimination rider" means a provision attached to a policy that excludes coverage for a specific  
13 condition that would otherwise be covered under the policy.

14 (6) "Enrollment date" means, with respect to an individual covered under a group health plan or  
15 health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the  
16 first day of the waiting period for enrollment.

17 (7) "Excepted benefits" means:

18 (a) coverage only for accident, disability income insurance, or both;

19 (b) coverage issued as a supplement to liability insurance;

20 (c) liability insurance, including general liability insurance and automobile liability insurance;

21 (d) workers' compensation or similar insurance;

22 (e) automobile medical payment insurance;

23 (f) credit-only insurance;

24 (g) coverage for onsite medical clinics;

25 (h) other similar insurance coverage under which benefits for medical care are secondary or  
26 incidental to other insurance benefits, as approved by the commissioner;

27 (i) if offered separately, any of the following:

28 (i) limited-scope dental or vision benefits;

29 (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any  
30 combination of these types of care; or

- 1 (iii) other similar, limited benefits as approved by the commissioner;
- 2 (j) if offered as independent, noncoordinated benefits, any of the following:
- 3 (i) coverage only for a specified disease or illness; or
- 4 (ii) hospital indemnity or other fixed indemnity insurance;
- 5 (k) if offered as a separate insurance policy:
- 6 (i) medicare supplement coverage;
- 7 (ii) coverage supplemental to the coverage provided under
- 8 Title 10, chapter 55, of the United States Code; and
- 9 (iii) similar supplemental coverage provided under a group health plan.
- 10 (8) "Federally defined eligible individual" means an individual:
- 11 (a) for whom, as of the date on which the individual seeks coverage in the group market or
- 12 individual market or under an association portability plan, as defined in 33-22-1501, the aggregate of the
- 13 periods of creditable coverage is 18 months or more;
- 14 (b) whose most recent prior creditable coverage was under a group health plan, governmental plan,
- 15 church plan, or health insurance coverage offered in connection with any of those plans;
- 16 (c) who is not eligible for coverage under:
- 17 (i) a group health plan;
- 18 (ii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42
- 19 U.S.C. 1395j through 1395w-4; or
- 20 (iii) a state plan under Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, or a
- 21 successor program;
- 22 (d) who does not have other health insurance coverage;
- 23 (e) for whom the most recent coverage within the period of aggregate creditable coverage was not
- 24 terminated for factors relating to nonpayment of premiums or fraud;
- 25 (f) who, if offered the option of continuation coverage under a COBRA continuation provision or
- 26 under a similar state program, elected that coverage; and
- 27 (g) who has exhausted continuation coverage under the COBRA continuation provision or program
- 28 described in subsection (8)(f) if the individual elected the continuation coverage described in subsection
- 29 (8)(f).
- 30 (9) "Group health insurance coverage" means health insurance coverage offered in connection with

a group health plan or health insurance coverage offered to an eligible group as described in 33-22-501.

(10) "Group health plan" means an employee welfare benefit plan, as defined in, 29 U.S.C. 1002(1), to the extent that the plan provides medical care and items and services paid for as medical care to employees or their dependents, directly or through insurance, reimbursement, or otherwise.

(11) "Health insurance coverage" means benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, through insurance, reimbursement, or otherwise, under a policy, certificate, membership contract, or health care services agreement offered by a health insurance issuer.

(12) "Health insurance issuer" means an insurer, a health service corporation, or a health maintenance organization.

(13) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(14) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(15) "Large employer" means, in connection with a group health plan, with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(16) "Large group market" means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a large employer.

(17) "Late enrollee" means an eligible employee or dependent who requests enrollment in a group health plan following the initial enrollment period during which the individual was entitled to enroll under the terms of the group health plan if the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent is not considered a late enrollee if:

(a) the individual requests enrollment within 63 days after termination of the creditable coverage and:

(i) the individual was covered under creditable coverage at the time of the initial enrollment; or  
(ii) the individual lost coverage under creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination of the creditable coverage, the death of a spouse, divorce, or legal separation;

(b) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(18) "Medical care" means:

(a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) transportation primarily for and essential to medical care referred to in subsection (18)(a); or

(c) insurance covering medical care referred to in subsections (18)(a) and (18)(b).

(19) "Network plan" means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(20) "Plan sponsor" has the meaning provided under section 3(16)(B) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1002(16)(B).

(21) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on presence of a condition before the enrollment date coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the enrollment date.

(22) "Small group market" means the health insurance market under which individuals obtain health insurance coverage directly or through an arrangement, on behalf of themselves and their dependents, through a group health plan maintained by a small employer, as defined in 33-22-1803.

(23) "Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the group health plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the group health plan.

**NEW SECTION. Section 34. Crediting previous coverage.** (1) A period of creditable coverage may not be counted, with respect to enrollment of an individual under a group health plan, if there was a 63-day break in coverage, during which the individual was not covered under any creditable coverage.

(2) The time that an individual is in a waiting period for coverage under a group health plan or for group health insurance coverage or is in an affiliation period, as defined in 33-31-102, may not be considered in determining the continuous period under subsection (1).

(3) Except as provided in subsection (4), for the purposes of applying [section ~~40~~ 39], a group health plan or a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits coverage during the period.

(4) (a) A group health plan or a health insurance issuer offering group health insurance may elect to apply the provisions of [section ~~40~~ 39] based on coverage of benefits within each of several classes or categories of benefits specified in regulations implementing Public Law 104-191, rather than as provided under subsection (3). If electing to apply the provisions of [section ~~40~~ 39] pursuant to this subsection (4), a group health plan or a health insurance issuer shall:

(i) make the election on a uniform basis for all participants and beneficiaries; and

(ii) count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(b) In the case of an election under this subsection (4), a group health plan shall:

(i) prominently state in a disclosure statement concerning the group health plan to each enrollee at the time of enrollment that the group health plan has made an election; and

(ii) include a description of the effect of the election in the statement.

(c) In the case of an election under this subsection (4), a health insurance issuer shall:

(i) prominently state in a disclosure statement concerning the health insurance coverage to each employer at the time of the offer or sale of the health insurance coverage that the health insurance issuer has made an election; and

(ii) include a description of the effect of the election in the statement.

(5) Periods of creditable coverage with respect to an individual must be established through presentation of certifications described in [section ~~37~~ 36] or in such other manner as may be specified in regulations implementing Public Law 104-191.

**NEW SECTION.** **Section 35. Special enrollment periods.** (1) A group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan shall permit an employee or a dependent of an employee who is eligible, but not enrolled, for coverage under



1 the terms of the group health plan to enroll for coverage under the terms of the group health plan if:

2 (a) the employee or dependent was covered under a group health plan or had health insurance  
3 coverage at the time that coverage was previously offered to the employee or dependent;

4 (b) the employee stated in writing at the time that coverage under a group health plan or health  
5 insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance  
6 issuer required the statement at the time and provided the employee with notice of the requirement and the  
7 consequences of the requirement at the time;

8 (c) the employee's or dependent's coverage described in subsection (1)(a) was:

9 (i) under a COBRA continuation provision and was exhausted; or

10 (ii) not under a COBRA continuation provision and was terminated as a result of loss of eligibility  
11 for the coverage or because employer contributions toward the coverage were terminated; and

12 (d) under the terms of the group health plan, the employee requests the enrollment not later than  
13 30 days after the date of exhaustion of coverage described in subsection (1)(c)(i) or termination of coverage  
14 or employer contribution described in subsection (1)(c)(ii).

15 (2) (a) A group health plan shall provide for a dependent special enrollment period described in  
16 subsection (2)(b) during which a dependent may be enrolled under the group health plan as a dependent  
17 of the individual and, in the case of the birth or adoption of a child, the spouse of the individual may be  
18 enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

19 (b) A dependent special enrollment period under this subsection (2) is a period of not less than 30  
20 days that begins on the later of:

21 (i) the date dependent coverage is made available; or

22 (ii) the date of the marriage, birth, or adoption or placement for adoption.

23 (3) If an individual seeks to enroll a dependent during the first 30 days of the dependent special  
24 enrollment period, the coverage of the dependent becomes effective:

25 (a) in the case of marriage, not later than the first day of the first month beginning after the date  
26 on which the completed request for enrollment is received;

27 (b) in the case of a dependent's birth, as of the date of birth; or

28 (c) in the case of a dependent's adoption or placement for adoption, the date of the adoption or  
29 placement for adoption.

30

1        **NEW SECTION. Section 36. Certification of creditable coverage.** (1) A group health plan and a  
2 health insurance issuer offering group health insurance coverage shall provide the certification described  
3 in subsection (3):

4            (a) at the time that an individual ceases to be covered under the group health plan or otherwise  
5 becomes covered under a COBRA continuation provision;

6            (b) in the case of an individual becoming covered under a COBRA continuation provision, at the  
7 time that the individual ceases to be covered under a COBRA continuation provision; and

8            (c) at the request on behalf of an individual made not later than 24 months after the date of  
9 termination of the coverage described in subsection (1)(a) or (1)(b), whichever is later.

10           (2) The certification pursuant to subsection (1)(a) may be provided, to the extent practicable, at  
11 a time consistent with notices required under any applicable COBRA continuation provision.

12           (3) Certification is the written:

13            (a) certification of the period of creditable coverage of the individual under a group health plan and  
14 the coverage under the COBRA continuation provision;

15            (b) certification of the waiting period, if any, and affiliation period, as defined in 33-31-102, if  
16 applicable, imposed with respect to the individual for any coverage under a group health plan; and

17            (c) notification to the individual of:

18            (i) the individual's option to apply to the Montana comprehensive health association, provided for  
19 in 33-22-1503, for an association portability plan, as defined in 33-22-1501, within 63 days of termination  
20 of creditable coverage;

21            (ii) the individual's conversion rights;

22            (iii) the availability of COBRA continuation coverage;

23            (iv) the telephone number and address of the Montana comprehensive health association; and

24            (v) other notification as determined necessary and in the form prescribed by rule by the  
25 commissioner.

26           (4) To the extent that medical care under a group health plan consists of group health insurance  
27 coverage, a group health plan satisfies the certification requirement of this section if the health insurance  
28 issuer offering the coverage provides the certification in accordance with this section.

29           (5) In the case of an election described in [section ~~35~~ 34] by a group health plan or health  
30 insurance issuer, if the group health plan or health insurance issuer enrolls an individual for coverage under

1 the group health plan and the individual provides a certification of coverage of the individual, the entity that  
2 issued the certification shall upon request of the group health plan or health insurance issuer promptly  
3 disclose information on coverage of classes and categories of health benefits available under the certified  
4 coverage. The entity may charge the requesting group health plan or health insurance issuer the reasonable  
5 cost of disclosing the information.

6 (6) This section applies to health insurance coverage offered by a health insurance issuer in the  
7 individual market in the same manner as it applies to health insurance coverage offered by a health  
8 insurance issuer in connection with a group health plan in the group market.

9  
10 **NEW SECTION. Section 37. Preexisting conditions relating to individual market.** (1) Except as  
11 provided in subsection (2), a health insurance issuer offering individual health insurance coverage may not  
12 exclude coverage for a preexisting condition unless:

13 (a) medical advice, diagnosis, care, or treatment was recommended to or received by the  
14 participant or beneficiary within the 3 years preceding the effective date of coverage; and

15 (b) coverage for the condition is excluded for not more than 12 months.

16 (2) A health insurance issuer offering health insurance coverage may not impose a preexisting  
17 condition exclusion on a federally defined eligible individual because of a preexisting condition.

18  
19 **NEW SECTION. Section 38. Guaranteed renewability of individual health insurance coverage.** (1)  
20 Except as provided in this section, a health insurance issuer that provides individual health insurance  
21 coverage to an individual shall renew or continue the coverage in force at the option of the individual.

22 (2) A health insurance issuer may nonrenew or discontinue health insurance coverage of an  
23 individual in the individual market only if:

24 (a) the individual has failed to pay premiums or contributions in accordance with the terms of the  
25 health insurance coverage or if the health insurance issuer has not received timely premium payments;

26 (b) the individual has performed an act or practice that constitutes fraud or has made an intentional  
27 misrepresentation of a material fact under the terms of the coverage;

28 (c) the health insurance issuer is ceasing to offer coverage in the individual market in accordance  
29 with this section and applicable state law;

30 (d) in the case of a health insurance issuer that offers health insurance coverage in the individual

1 market through a network plan, the individual no longer lives, resides, or works in the service area of the  
2 health insurance issuer or in an area for which the health insurance issuer is authorized to do business, but  
3 only if the coverage is terminated under this subsection (2)(d) uniformly without regard to any health  
4 status-related factor of covered individuals; or

5 (e) in the case of health insurance coverage that is made available in the individual market only  
6 through one or more bona fide associations, as defined in 33-22-1803, the membership of the individual  
7 in the bona fide association ceases, but only if the coverage is terminated under this subsection (2)(e)  
8 uniformly without regard to any health status-related factor of a covered individual.

9 (3) A health insurance issuer may not discontinue offering a particular type of individual health  
10 insurance coverage offered in the individual market unless in accordance with applicable state law and  
11 unless:

12 (a) the health insurance issuer gives notice to each covered individual provided coverage of this  
13 type in the individual market of the discontinuation at least 90 days prior to the date of the discontinuation  
14 of the coverage;

15 (b) the health insurance issuer offers to each individual in the individual market provided coverage  
16 of this type the option to purchase any other individual health coverage currently being offered by the  
17 health insurance issuer to individuals in the individual market; and

18 (c) in exercising the option to discontinue coverage of this type and in offering the option of  
19 coverage under subsection (3)(b), the health insurance issuer acts uniformly, without regard to the claims  
20 experience of individuals or any health status-related factor of individuals who may become eligible for the  
21 coverage.

22 (4) (a) A health insurance issuer may not discontinue offering all health insurance coverage in the  
23 individual market unless in accordance with applicable state law and unless:

24 (i) the health insurance issuer provides notice of discontinuation to the commissioner and each  
25 covered individual at least 180 days prior to the date of the discontinuation of coverage; and

26 (ii) all health insurance issued or delivered for issuance in Montana in the individual market is  
27 discontinued and coverage under the health insurance coverage in the individual market is not renewed.

28 (b) In the case of a discontinuation under subsection (4)(a) in the individual market, the health  
29 insurance issuer may not provide for the issuance of any health insurance coverage in the individual market  
30 during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage

1 not renewed.

2 (5) A health insurance issuer may modify upon renewal health insurance coverage for a policy form  
3 offered to individuals in the individual market if the modification is consistent with applicable state law and  
4 effective on a uniform basis among all individuals with that policy form.

5 (6) In the case of health insurance coverage that is made available by a health insurance issuer in  
6 the individual market to individuals only through one or more bona fide associations, references to  
7 "individual" under this section include a reference to the bona fide association of which the individual is  
8 a member.

9  
10 **NEW SECTION. Section 39. Preexisting conditions relating to group market.** (1) A group health  
11 plan or a health insurance issuer offering group health insurance coverage may not exclude coverage for  
12 a preexisting condition unless:

13 (a) medical advice, diagnosis, care, or treatment was recommended or received by the participant  
14 or beneficiary within the 6-month period ending on the enrollment date;

15 (b) exclusion of coverage extends for a period of not more than 12 months; and

16 (c) the period of the preexisting condition exclusion is reduced by the aggregate of the periods of  
17 creditable coverage applicable to the participant or beneficiary as of the enrollment date.

18 (2) Genetic information may not be excluded as a preexisting condition in the absence of a  
19 diagnosis of the condition related to the genetic information.

20 (3) Pregnancy may not be excluded as a preexisting condition.

21  
22 **NEW SECTION. Section 40. Guaranteed renewability of coverage for employers in group market.**

23 (1) Except as provided in this section, if a health insurance issuer offers health insurance coverage in the  
24 small group market or large group market in connection with a group health plan, the health insurance  
25 issuer shall renew or continue the coverage in force at the option of the plan sponsor.

26 (2) A health insurance issuer may nonrenew or discontinue health insurance coverage offered in  
27 connection with a group health plan in the small group market or large group market if:

28 (a) the plan sponsor has failed to pay premiums or contributions in accordance with the terms of  
29 the health insurance coverage or if the health insurance issuer has not received timely premium payments;

30 (b) the plan sponsor has performed an act or practice that constitutes fraud or has made an

1 intentional misrepresentation of material fact under the terms of the coverage;

2 (c) the plan sponsor has failed to comply with a material plan provision relating to employer  
3 contribution or group health plan participation rules in the case of the small group market or pursuant to  
4 applicable state law in the case of the large group market;

5 (d) the health insurance issuer is ceasing to offer coverage in that group market in accordance with  
6 this section and applicable state law;

7 (e) in the case of a health insurance issuer that offers health insurance coverage in the group  
8 market through a network plan, there is no longer any enrollee in connection with the group health plan  
9 who lives, resides, or works in the service area of the health insurance issuer and, in the case of the small  
10 group market, if the health insurance issuer would deny enrollment with respect to the plan under  
11 33-22-1811(4)(a)(i); or

12 (f) in the case of health insurance coverage that is made available in the small group market or large  
13 group market only through one or more bona fide associations, the membership of an employer in the bona  
14 fide association ceases, but only if the coverage is terminated under this subsection (2)(f) uniformly without  
15 regard to any health status-related factor of a covered individual.

16 (3) A health insurance issuer may not discontinue offering a particular type of group health  
17 insurance coverage offered in the small group market or large group market unless in accordance with  
18 applicable state law and unless:

19 (a) the issuer provides notice to each plan sponsor, participant, and beneficiary provided coverage  
20 of this type in that group market of the discontinuation at least 90 days prior to the date of the  
21 discontinuation of the coverage;

22 (b) the issuer offers to each plan sponsor provided coverage of this type in the market the option  
23 to purchase any other health insurance coverage currently being offered by the health insurance issuer to  
24 a group health plan in the market; and

25 (c) the health insurance issuer acts uniformly without regard to the claims experience of those  
26 sponsors or any health status-related factor of any participants or beneficiaries covered or new participants  
27 or beneficiaries who may become eligible for the coverage.

28 (4) (a) A health insurance issuer may not discontinue offering all health insurance coverage in the  
29 small group market, the large group market, or both the small group market and the large group market,  
30 unless in accordance with applicable state law and unless:

1 (i) the issuer provides notice of discontinuation to the commissioner and to each plan sponsor,  
2 participant, and beneficiary covered at least 180 days prior to the date of the discontinuation of coverage;  
3 and

4 (ii) all health insurance issued or delivered for issuance in Montana in the group market or markets  
5 is discontinued and coverage under the health insurance coverage in the group market or markets is not  
6 renewed.

7 (b) In the case of a discontinuation under this section in a group market, the health insurance issuer  
8 may not provide for the issuance of any health insurance coverage in the group market for a period of 5  
9 years beginning on the date of the discontinuation of the last health insurance coverage not renewed.

10 (5) A health insurance issuer may modify upon renewal health insurance coverage for a product  
11 offered to a group health plan in the large group market or in the small group market if, for coverage that  
12 is available in the small group market other than only through one or more bona fide associations,  
13 modification is consistent with applicable state law and effective on a uniform basis among group health  
14 plans with that product.

15 (6) In the case of health insurance coverage that is made available by a health insurance issuer in  
16 the small group market or large group market to employers only through one or more bona fide  
17 associations, references to "plan sponsor" under this section include those employers.

18  
19 **NEW SECTION. Section 41. Association portability plans.** (1) The association shall offer at least  
20 two comprehensive health benefit plans designed by the association. The association portability plans may  
21 not be delivered or issued for delivery in this state until the policy forms and rates are approved by the  
22 commissioner, in accordance with rules adopted by the commissioner. **THE COMMISSIONER MAY BY**  
23 **ORDER EXTEND THE DATE BY WHICH THE ASSOCIATION SHALL OFFER THE ASSOCIATION**  
24 **PORTABILITY PLAN UNTIL A DATE NOT LATER THAN JANUARY 1, 1998.**

25 (2) The association shall administer the association portability plans as a distinctly separate block  
26 of business from the association plan. The claims experience or the expense experience of the association  
27 plan may not be combined with the claims experience or expense experience of any association portability  
28 plan in the determination of association portability plan premium rates or reserves of any association  
29 portability plan.

1        **NEW SECTION. Section 42. Guaranteed renewability in multiple employer welfare arrangements.**

2        A group health plan that is a multiple employer welfare arrangement, as defined by 29 U.S.C. 1002, may  
3        not deny an employer whose employees are covered under the group health plan continued access to the  
4        same or different coverage under the terms of the group health plan other than:

5            (1) for nonpayment of contributions;

6            (2) for fraud or other intentional misrepresentation of material fact by the employer;

7            (3) for noncompliance with material plan provisions;

8            (4) because the group health plan is ceasing to offer any coverage in a geographic area;

9            (5) in the case of a group health plan that offers benefits through a network plan, because there  
10        is no longer any individual enrolled through the employer who lives, resides, or works in the service area  
11        of the network plan and the group health plan applies to this section uniformly without regard to the claims  
12        experience of employers or any health status-related factor of those individuals or their dependents; or

13            (6) for failure to meet the terms of an applicable collective bargaining agreement, to renew a  
14        collective bargaining or other agreement requiring or authorizing contributions to the group health plan, or  
15        to employ employees covered by the agreement.

16  
17        **NEW SECTION. Section 43. Affiliation periods.** (1) A health maintenance organization that offers  
18        health insurance coverage in connection with a group health plan and that does not impose a preexisting  
19        condition exclusion allowed by [section ~~38~~ 37] or [section ~~40~~ 39] with respect to any particular coverage  
20        option may impose an affiliation period for that coverage option if:

21            (a) the affiliation period is applied uniformly without regard to any health status-related factors; and

22            (b) the affiliation period does not exceed 2 months, or 3 months in the case of a late enrollee, as  
23        defined in [section ~~34~~ 33].

24            (2) A health maintenance organization is not required to provide health care services or benefits  
25        during the affiliation period, and a premium may not be charged to the participant or beneficiary for any  
26        coverage during the affiliation period. An affiliation period begins on the enrollment date and runs  
27        concurrently with any waiting period under the plan.

28            (3) A health maintenance organization may use a method other than an affiliation period to address  
29        adverse selection if the method is approved by the commissioner.

30            (4) The definitions in [section ~~34~~ 33] apply to this section.



**NEW SECTION. Section 44. Group health discrimination prohibited.** (1) (a) A group health plan

or a health insurance issuer offering group health insurance coverage may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the group health plan based on any of the following health status-related factors of the individual or a dependent of the individual:

(i) health status;

(ii) medical condition, including both physical and mental illnesses;

(iii) claims experience;

(iv) receipt of health care;

(v) medical history;

(vi) genetic information;

(vii) evidence of insurability, including conditions arising out of acts of domestic violence; or

(viii) disability.

(b) This subsection does not:

(i) require a group health plan or group health insurance coverage to provide particular benefits other than those provided under the terms of the group health plan or group health insurance coverage; or

(ii) prevent the group health plan or group health insurance coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the group health plan or group health insurance coverage.

(c) For purposes of subsection (1)(a), rules for eligibility to enroll under a group health plan include rules defining an applicable waiting period for the enrollment.

(2) (a) A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan may not require an individual, as a condition of enrollment or continued enrollment under the group health plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the group health plan on the basis of any health status-related factor of the individual or of an individual enrolled under the plan as a dependent of the individual.

(b) This subsection (2) does not:

(i) restrict the amount that an employer may be charged for coverage under a group health plan; or

(ii) prevent a group health plan and a health insurance issuer offering group health insurance

coverage from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

NEW SECTION. Section 45. Rules. The commissioner may adopt rules to implement [sections 34 through 43 and 45 33 THROUGH 42 AND 44].

NEW SECTION. Section 47. Short title. [Sections 47 through 61] may be cited as the "Viatical Settlement Act".

NEW SECTION. Section 48. Definitions. As used in [sections 47 through 61], unless the context requires otherwise, the following definitions apply:

(1) (a) ~~"Viatical settlement broker" means an individual who, for a fee, commission, or other consideration;~~

~~(i) offers or advertises the availability of viatical settlement contracts;~~

~~(ii) introduces holders of life insurance policies or certificates insuring the lives of individuals with a terminal illness or condition to viatical settlement providers; or~~

~~(iii) offers or attempts to negotiate viatical settlement contracts between the policyholders or certificate holders and one or more viatical settlement providers.~~

~~(b) Viatical settlement broker does not mean an attorney, accountant, or financial planner retained to represent the policyholder or certificate holder unless compensation paid to the attorney, accountant, or consultant is paid by the viatical settlement provider.~~

(2) ~~"Viatical settlement contract" means a written agreement between a viatical settlement provider and the holder of a group or individual life insurance policy insuring the life of an individual with a terminal illness or condition or between a viatical settlement provider and the certificate holder of a policy in which:~~

~~(a) the terms establish that the viatical settlement provider pays something of value in return for the policyholder's or certificate holder's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the insurance policy or certificate to the viatical settlement provider; and~~

~~(b) the policyholder or certificate holder holds an irrevocable right under the policy or certificate to name the beneficiary.~~

(3) (a) ~~"Viatical settlement provider" means a person who solicits, enters into, or negotiates viatical~~

~~settlement contracts or offers to enter into or negotiate viatical settlement contracts.~~

~~(b) A viatical settlement provider may use the term "life settlement provider" to describe the business transacted under the license and may use the term "life settlement contract" instead of "viatical settlement contract".~~

~~(c) Viatical settlement provider does not mean:~~

~~(i) a bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy only as collateral for a loan;~~

~~(ii) an insurer issuing a life insurance policy providing accelerated benefits pursuant to 33-20-127 or pursuant to the laws of the state to which the policy was subject when issued;~~

~~(iii) an individual who enters into a single agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit; or~~

~~(iv) any corporation, partnership, or partner that purchases a life insurance contract of an employee or retiree of the corporation or of a partner. The settlement made on a contract exempt pursuant to this section must be reasonable and is subject to the standards imposed on licensees under {section 50}.~~

~~**NEW SECTION. Section 49. License application.** (1) A person may not act as or purport to be a viatical settlement provider or viatical settlement broker unless licensed as a viatical settlement provider or viatical settlement broker under {sections 47 through 61}.~~

~~(2) In order to obtain a license to transact business as a viatical settlement provider or as a viatical settlement broker, an applicant shall apply for the license on forms prescribed by the commissioner and shall pay the fee required for the application.~~

~~(3) The commissioner may request biographical, organizational, locational, financial, employment, and other information on the application form that the commissioner determines to be relevant to the evaluation of applications and to the granting of the license. The commissioner may require a statement of the business plan or plan of operation of the applicant. The commissioner shall require an applicant for a viatical settlement provider license to file with the application for the commissioner's approval a copy of the viatical settlement contract that the applicant intends to use in business under the license.~~

~~(4) If an applicant is a corporation, the corporation must be:~~

~~(a) incorporated or organized under the laws of this state; or~~

~~(b) a foreign corporation authorized to transact business in this state.~~

~~(5) If the applicant is a partnership, the partnership must be organized under the laws of this state.~~

~~**NEW SECTION. Section 50. Issuance of license.** (1) The commissioner may issue a license to the applicant if the commissioner determines that the applicant:~~

~~(a) has satisfied all of the requirements for the license for which an application is made;~~

~~(b) has not engaged in conduct that would authorize the commissioner to refuse to issue a license under [sections 47 through 61]; and~~

~~(c) is financially responsible and has a good business reputation.~~

~~(2) The commissioner may issue a license to a nonresident applicant only if the nonresident applicant files with the commissioner in writing an appointment of the commissioner to be the agent of the applicant upon whom all legal process in any action or proceeding against the applicant may be served. In the appointment, the applicant shall agree that any lawful process against the applicant that is served upon the commissioner is of the same legal force and validity as if served upon the applicant and that the authority will continue in force as long as any liability remains outstanding in this state. An appointment under this subsection becomes effective on the date that the commissioner issues the license to the applicant.~~

~~(3) If the commissioner denies an application, the commissioner shall inform the applicant and state the grounds for the denial.~~

~~(4) An individual may act as a viatical settlement provider or viatical settlement broker under the authority of the license of a firm or of a corporate viatical settlement provider whether or not the individual holds a license as a viatical settlement provider if:~~

~~(a) the individual is a member or employee of the firm or is an employee, officer, or director of the corporation; and~~

~~(b) the individual is designated by the firm or corporation on its license application or on a form that amends or supplements the application as being authorized to act as a viatical settlement provider under the authority of the license.~~

~~**NEW SECTION. Section 51. Expiration of license.** (1) A license issued under [sections 47 through 61] expires on its expiration date unless it is renewed on or before its expiration date.~~

~~(2) Unless the commissioner designates another date, a license expires on the last day of the~~

1 month in which the second anniversary of the initial issuance date of the license occurs and on the last day  
2 of the month of the second anniversary following each renewal.

3  
4 ~~NEW SECTION. Section 52. Notification by licensee of material change affecting qualification for~~  
5 ~~license. A licensee shall immediately notify the commissioner of any material change in ownership or~~  
6 ~~control or in any other matter affecting the qualification of the licensee for the license in this state, including~~  
7 ~~keeping the commissioner informed about personnel and address changes.~~

8  
9 ~~NEW SECTION. Section 53. Suspension—revocation—refusal to issue or renew license. (1) The~~  
10 ~~commissioner may suspend, revoke, refuse to issue, or refuse to renew a license if the commissioner~~  
11 ~~determines that the licensee or applicant for a license is untrustworthy or incompetent to act as a licensee~~  
12 ~~or is guilty of one or more of the following:~~

- 13 (a) ~~dishonesty, fraud, or gross negligence in the conduct of business as a licensee;~~  
14 (b) ~~a pattern of unreasonable payments to policyholders or certificate holders;~~  
15 (c) ~~falsification of an application for the license or renewal of the license or misrepresentation or~~  
16 ~~engagement in any other dishonest act in relation to the application;~~  
17 (d) ~~conduct resulting in a conviction of a felony under the laws of any state or of the United States;~~  
18 (e) ~~conviction of any crime, an essential element of which is dishonesty or fraud, under the laws~~  
19 ~~of any state or of the United States;~~  
20 (f) ~~refusal to renew or cancellation, revocation, or suspension of authority to transact insurance~~  
21 ~~or business as a viatical settlement provider, viatical settlement broker, or similar entity in another state;~~  
22 (g) ~~failure to pay a civil penalty imposed by final order of the commissioner or to carry out terms~~  
23 ~~of probation set by the commissioner;~~  
24 (h) ~~refusal by a licensee to be examined or to produce accounts, records, or files for examination,~~  
25 ~~refusal by any officers or employees to give information with respect to the affairs of the licensee, or~~  
26 ~~refusal to perform any other legal obligation as to the examination, when required by the commissioner;~~  
27 (i) ~~affiliation with or under the same general management or interlocking directorate or ownership~~  
28 ~~as another viatical settlement provider, viatical settlement broker, or insurer, any of which unlawfully~~  
29 ~~transacts business in this state;~~  
30 (j) ~~failure at any time to meet any qualification for which issuance of the license could have been~~

1 ~~refused had the failure then existed and been known to the commissioner; or~~

2 ~~(k) violation of any rule or order of the commissioner or any provision of Montana law.~~

3 ~~(2) The commissioner may suspend or refuse to renew a license immediately and without hearing~~  
4 ~~if the commissioner determines that one or both of the following circumstances exist:~~

5 ~~(a) the licensee is insolvent;~~

6 ~~(b) the financial condition or business practices of the licensee otherwise pose an imminent threat~~  
7 ~~to the public health, safety, or welfare of the residents of this state.~~

8 ~~(3) The commissioner may refuse to issue a license in the name of any firm, partnership, or~~  
9 ~~corporation if the commissioner believes that any officer, employee, stockholder, or partner who may~~  
10 ~~materially influence the conduct of the applicant does not meet the standards of this section.~~

11 ~~(4) A viatical settlement provider or viatical settlement broker holding a license that has not been~~  
12 ~~renewed or that has been revoked shall surrender the license to the commissioner at the commissioner's~~  
13 ~~request.~~

14 ~~(5) The commissioner may take any other administrative action authorized under Montana law in~~  
15 ~~addition to or in lieu of the actions authorized under [sections 47 through 61].~~

16

17 ~~**NEW SECTION. Section 54. Terms of contract.** (1) A viatical settlement contract must be in~~  
18 ~~writing. A viatical settlement provider shall establish in the contract the terms under which the viatical~~  
19 ~~settlement provider will pay compensation or anything of value in return for the policyholder's or certificate~~  
20 ~~holder's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the insurance~~  
21 ~~policy or certificate to the viatical settlement provider.~~

22 ~~(2) A viatical settlement provider may not use a viatical settlement contract in this state unless the~~  
23 ~~viatical settlement provider has filed the contract form with the commissioner and the commissioner has~~  
24 ~~approved the contract form according to the provisions set forth in 33-1-501. The commissioner shall~~  
25 ~~disapprove a viatical settlement contract form if, in the commissioner's judgment, the contract or any~~  
26 ~~provision of the contract is unreasonable, contrary to the interests of the public, or otherwise misleading~~  
27 ~~or unfair to the policyholder or certificate holder.~~

28 ~~(3) Each viatical settlement contract entered into in this state must contain a provision enabling~~  
29 ~~the policyholder or certificate holder to rescind the contract not later than the 30th day after the date on~~  
30 ~~which the contract is executed by all parties or not later than the 15th day after the policyholder or~~

1 ~~certificate holder receives the viatical settlement proceeds, whichever is the longer period. In order to~~  
2 ~~renew a contract, a policyholder or certificate holder who has received the proceeds shall return them to~~  
3 ~~the viatical settlement provider.~~

4  
5 ~~NEW SECTION. Section 55. Annual report by provider. Unless the commissioner grants a time~~  
6 ~~extension, a viatical settlement provider shall file a report for the preceding calendar year with the~~  
7 ~~commissioner on or before March 1 of each year. The report must be in the form and must contain the~~  
8 ~~information that the commissioner prescribes. The report must be verified as follows:~~

9 ~~(1) if the viatical settlement provider is a corporation, by at least two principal officers of the~~  
10 ~~viatical settlement provider;~~

11 ~~(2) if the viatical settlement provider is a partnership, by two partners; or~~

12 ~~(3) if the viatical settlement provider is not a corporation or a partnership, by the provider's owner~~  
13 ~~and manager.~~

14  
15 ~~NEW SECTION. Section 56. Examination of business and practices of licensee or applicant~~  
16 ~~maintenance of business records. (1) The commissioner may examine the business and practices of any~~  
17 ~~licensee or applicant for a license when the commissioner determines an examination to be necessary. The~~  
18 ~~commissioner may order a licensee or applicant to produce any records, books, files, or other information~~  
19 ~~reasonably necessary to ascertain whether the licensee or applicant is acting or has acted in violation of~~  
20 ~~the law or contrary to the interests of the public. The licensee or applicant shall pay the expenses incurred~~  
21 ~~in conducting any examination.~~

22 ~~(2) A viatical settlement provider shall maintain records of all transactions of viatical settlement~~  
23 ~~contracts of the viatical settlement provider and shall make the records available to the commissioner for~~  
24 ~~inspection during reasonable business hours. The records must be maintained for a period of not less than~~  
25 ~~5 years from the date of their creation.~~

26 ~~(3) The commissioner may at any time require a licensee to fully disclose the identity of all~~  
27 ~~stockholders, partners, officers, and employees.~~

28 ~~(4) The names of and individual identification data for all policyholders and certificate holders who~~  
29 ~~have entered viatical settlement contracts with viatical settlement providers are confidential and may not~~  
30 ~~be disclosed except as considered necessary by the commissioner in administration of [sections 47 through~~

1     ~~61).~~

2

3             ~~NEW SECTION. Section 57. Disclosure of information to policyholder.~~ A viatical settlement  
4     ~~provider shall disclose the information specified in this section to the policyholder or certificate holder~~  
5     ~~entering the viatical settlement contract prior to the date on which the viatical settlement contract is signed~~  
6     ~~by all parties. The disclosure must be in the form prescribed by the commissioner. The information must~~  
7     ~~include the following:~~

8             ~~(1) possible alternatives to viatical settlement contracts for persons with terminal illnesses or~~  
9     ~~conditions, including but not limited to accelerated benefits offered by the issuer of the life insurance policy;~~

10            ~~(2) the fact that some or all of the proceeds of the viatical settlement may be taxable and that~~  
11     ~~assistance should be sought from a personal tax advisor. Viatical settlement brokers, viatical settlement~~  
12     ~~providers, or their respective employees or agents may not act as personal tax advisors for purposes of this~~  
13     ~~disclosure requirement.~~

14            ~~(3) the fact that the viatical settlement could be subject to the claims of creditors;~~

15            ~~(4) the fact that receipt of a viatical settlement may adversely affect the recipient's eligibility for~~  
16     ~~medicaid or other government benefits or entitlement and that advice should be obtained from the~~  
17     ~~appropriate agencies;~~

18            ~~(5) the right of a policyholder or certificate holder to rescind a viatical settlement contract as~~  
19     ~~provided in [section 54]. The disclosure must state the deadlines for rescission and the return of proceeds~~  
20     ~~received.~~

21            ~~(6) the date by which the funds will be available to the policyholder or certificate holder and the~~  
22     ~~source of the funds; and~~

23            ~~(7) the fact that the viatical settlement contract is void if the viatical settlement provider or viatical~~  
24     ~~settlement broker fails to tender payment of the proceeds as provided in the viatical settlement contract.~~

25

26            ~~NEW SECTION. Section 58. Conditions precedent to entering into viatical settlement contract.~~

27     ~~(1) Before a viatical settlement provider enters into a viatical settlement contract with a policyholder or~~  
28     ~~certificate holder who has a terminal illness or condition, the viatical settlement provider shall first obtain~~  
29     ~~the following:~~

30            ~~(a) a written statement from an attending physician that the policyholder or certificate holder is of~~



1 ~~sound mind and not under constraint or undue influence; and~~

2 ~~(b) a witnessed document in which the policyholder or certificate holder:~~

3 ~~(i) consents to the viatical settlement contract;~~

4 ~~(ii) acknowledges that the illness or condition is terminal;~~

5 ~~(iii) represents that the policyholder or certificate holder has a full and complete understanding of~~  
6 ~~the viatical settlement contract;~~

7 ~~(iv) confirms that the policyholder or certificate holder has a full and complete understanding of the~~  
8 ~~benefits of the life insurance policy;~~

9 ~~(v) releases the medical records of the policyholder or certificate holder relating to the terminal~~  
10 ~~illness or condition; and~~

11 ~~(vi) acknowledges that the policyholder or certificate holder has entered into the viatical settlement~~  
12 ~~contract freely and voluntarily.~~

13 ~~(2) A viatical settlement provider may enter a viatical settlement contract only after the individual~~  
14 ~~whose life would be the subject of the viatical settlement contract is determined to have a terminal illness~~  
15 ~~or condition, as follows:~~

16 ~~(a) if the individual is the policyholder or certificate holder, an attending physician of the~~  
17 ~~policyholder or certificate holder shall make the determination; or~~

18 ~~(b) if the individual is a person other than the policyholder or certificate holder, an attending~~  
19 ~~physician of the individual or of the policyholder or certificate holder shall make the determination.~~

20 ~~(3) For purposes of this section, "attending physician" means a medical doctor, a doctor of~~  
21 ~~osteopathy, or a naturopathic physician licensed in this state, who is primarily responsible for the treatment~~  
22 ~~or a portion of treatment of the individual whose life would be the subject of the viatical settlement~~  
23 ~~contract.~~

24  
25 ~~**NEW SECTION. Section 59. Prohibitions on finder's fee solicitations—discrimination—false or**~~  
26 ~~**misleading advertising or solicitation—misuse of confidential information.** (1) A licensee may not pay or~~  
27 ~~offer to pay a finder's fee, commission, or other compensation to a person described in this subsection (1)~~  
28 ~~in connection with a policy insuring the life of an individual with a terminal illness or condition. The~~  
29 ~~prohibition under this subsection (1) applies with respect to payments or offers of payment to:~~

30 ~~(a) the physician, attorney, or accountant of the policyholder, the certificate holder, or the insured~~

1 individual;

2 (b) ~~any person other than a physician, attorney, or accountant described in subsection (1)(a) who~~  
3 ~~provides medical, legal, or financial planning services to the policyholder, to the certificate holder, or to the~~  
4 ~~insured individual when the individual is other than the policyholder or certificate holder; or~~

5 (c) ~~any person other than one described in subsection (1)(a) or (1)(b) who acts as an agent of the~~  
6 ~~policyholder, certificate holder, or insured individual.~~

7 (2) ~~A licensee may not solicit an investor who could influence the treatment of the illness or~~  
8 ~~condition of the individual whose life would be the subject of a viatical settlement contract.~~

9 (3) ~~All information solicited or obtained from a policyholder or certificate holder by a licensee is~~  
10 ~~subject to the confidentiality requirements set forth in Title 33, chapter 19. For purposes of this subsection,~~  
11 ~~a licensee must be considered an insurance support organization as defined in 33-19-104.~~

12 (4) ~~A licensee may not discriminate in the making of a viatical settlement contract on the basis of~~  
13 ~~race, age, sex, national origin, creed, religion, occupation, marital or family status, or sexual orientation and~~  
14 ~~may not discriminate between persons who have dependents and persons who do not have dependents.~~

15 (5) ~~A person licensed pursuant to [section 50] may not engage in any false or misleading~~  
16 ~~advertising, solicitation, or practice as described in 33-18-203.~~

17 (6) ~~A person licensed pursuant to [section 50] may not sell another product of insurance to the~~  
18 ~~contract holder unless approval is obtained from the commissioner.~~

19

20 ~~**NEW SECTION. Section 60. Payment to escrow or trust account — lump sum payment. (1)**~~

21 ~~Immediately upon receipt of documents from the policyholder or certificate holder effecting the transfer of~~  
22 ~~the insurance policy or certificate, the viatical settlement provider shall pay the proceeds of the settlement~~  
23 ~~to an escrow or trust account managed by a trustee or escrow agent in a bank approved by the~~  
24 ~~commissioner, pending acknowledgment of the transfer by the issuer of the life insurance policy. The~~  
25 ~~trustee or escrow agent shall transfer the proceeds due to the policyholder or certificate holder immediately~~  
26 ~~upon receipt of acknowledgment of the transfer from the insurer.~~

27 (2) ~~A viatical settlement provider shall make payment of the proceeds of a viatical settlement~~  
28 ~~contract in a lump sum except as provided in this subsection. A viatical settlement provider may not retain~~  
29 ~~any portion of the proceeds. A viatical settlement provider may make installment payments only if the~~  
30 ~~viatical settlement provider has purchased an annuity issued by an authorized insurer or a similar financial~~

1 instrument issued by a financial institution authorized to engage in the business of a financial institution in  
2 this state.

3 ~~(3) Failure by the viatical settlement provider to tender the viatical settlement by the date disclosed~~  
4 ~~to the policyholder or certificate holder renders the contract void.~~

5  
6 ~~NEW SECTION. Section 61. Rules standards bond. The commissioner may, in accordance~~  
7 ~~with the provisions of 33-1-313, adopt rules for the purpose of carrying out [sections 47 through 61]. In~~  
8 ~~addition, the commissioner:~~

9 ~~(1) may establish standards for evaluating reasonableness of payments under viatical settlement~~  
10 ~~contracts. The authority includes but is not limited to regulation of discount rates used to determine the~~  
11 ~~amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a life~~  
12 ~~insurance policy. For the purpose of the standards, the commissioner shall consider payments made in~~  
13 ~~regional and national viatical settlement markets to the extent that this information is available, as well as~~  
14 ~~model standards developed by the national association of insurance commissioners.~~

15 ~~(2) shall require a bond and an errors and omissions insurance policy of both kinds of licensees;~~  
16 ~~and~~

17 ~~(3) shall adopt rules to establish trade practice standards for the purpose of regulating advertising~~  
18 ~~and solicitation of viatical settlement contracts.~~

19  
20 ~~NEW SECTION. Section 62. Coverage for minimum hospital stay following childbirth. (1) For the~~  
21 ~~purposes of this section, "attending health care provider" means a person licensed under Title 37 who is~~  
22 ~~responsible for providing obstetrical and pediatric care to a mother and newborn infant.~~

23 ~~(2) Each group or individual policy, certificate of disability insurance, subscriber contract,~~  
24 ~~membership contract, or health care services agreement that provides coverage for maternity services,~~  
25 ~~including benefits for childbirth, must provide coverage for at least 48 hours of inpatient hospital care~~  
26 ~~following a vaginal delivery and at least 96 hours of inpatient hospital care following delivery by cesarean~~  
27 ~~section for a mother and newborn infant in a health care facility as defined in 50-5-101.~~

28 ~~(3) A decision to shorten the length of inpatient stay to less than that provided under subsection~~  
29 ~~(2) must be made by the attending health care provider and the mother. A health benefit plan, as defined~~  
30 ~~in 33-22-1803, may not terminate the service of an attending health care provider or penalize or otherwise~~

1 ~~provide financial disincentives to an attending health care provider in response to orders by the attending~~  
 2 ~~health care provider for care consistent with the provisions of this section.~~

3 ~~(4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother~~  
 4 ~~and newborn infant in the home may not be required to provide coverage of inpatient care under subsection~~  
 5 ~~(2) unless the inpatient care is determined to be medically necessary by the attending health care provider.~~

6 ~~(5) A health benefit plan shall provide written notice, in a manner consistent with the provisions~~  
 7 ~~of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section.~~

8  
 9 NEW SECTION. Section 63. Coverage for minimum hospital stay following childbirth. (1) ~~For the~~  
 10 ~~purposes of this section, "attending health care provider" means a person licensed under Title 37 who is~~  
 11 ~~responsible for providing obstetrical and pediatric care to a mother and newborn infant.~~

12 ~~(2) Each disability insurance plan or group disability insurance plan that is delivered, issued for~~  
 13 ~~delivery, renewed, extended, or modified in this state by a health service corporation that provides coverage~~  
 14 ~~for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of~~  
 15 ~~inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by~~  
 16 ~~cesarean section for a mother and newborn infant in a health care facility as defined in 50-5-101.~~

17 ~~(3) A decision to shorten the length of inpatient stay to less than that provided under subsection~~  
 18 ~~(2) must be made by the attending health care provider and the mother. A health services corporation may~~  
 19 ~~not terminate the service of an attending health care provider or penalize or otherwise provide financial~~  
 20 ~~disincentives to an attending health care provider in response to orders by the attending health care~~  
 21 ~~provider for care consistent with the provisions of this section.~~

22 ~~(4) A membership contract that provides coverage for postdelivery care that is provided to a~~  
 23 ~~mother and newborn infant in the home may not be required to provide coverage of inpatient hospital care~~  
 24 ~~under subsection (2) unless the inpatient hospital care is determined to be medically necessary by the~~  
 25 ~~attending health care provider.~~

26 ~~(5) A health service corporation shall provide written notice, in a manner consistent with the~~  
 27 ~~provisions of this chapter, to all enrollees, members, beneficiaries, insureds, or subscribers regarding the~~  
 28 ~~coverage required by this section.~~

29  
 30 NEW SECTION. Section 46. Policy waiting periods not cumulative. A waiting or elimination period

1 contained in a long-term care insurance policy under which an insured is required to wait a specified period  
2 of time before receiving policy benefits must be concurrent with any 90-day period used to determine  
3 whether an individual is a chronically ill individual.

4  
5 **NEW SECTION. Section 47. Delivery of policy or certificate.** If an application for a long-term care  
6 insurance policy or a certificate meeting the requirements of Public Law 104-191 is approved, the health  
7 insurance issuer of the policy or certificate shall deliver the policy or certificate to the applicant,  
8 policyholder, or certificate holder not later than 30 days after the date of issue.

9  
10 **NEW SECTION. Section 48. Denial of claims.** If a claim under a long-term care insurance policy  
11 or certificate meeting the requirements of Public Law 104-191 is denied, the health insurance issuer shall,  
12 not later than 60 days after the receipt of a written request by the policy holder, certificate holder, or the  
13 representative of either of them:

14 (1) provide a written explanation of the reasons for the denial; and

15 (2) provide all information possessed by the health insurance issuer relating to the denial.

16  
17 **NEW SECTION. Section 49. Benefit triggers.** (1) A long-term care insurance policy or certificate  
18 may not be delivered or issued for delivery in this state unless it complies with the requirements, as  
19 established by rules of the commissioner, for the triggering of mandatory provision of benefits.

20 (2) A qualified long-term care insurance contract must condition the payment of benefits on a  
21 determination of the insured's inability to perform activities of daily living for an expectation of at least 90  
22 days because of a loss of level of disability described under regulations adopted by the U.S. secretary of  
23 the treasury and because of:

24 (a) a loss of functional capacity requiring the substantial assistance of another person to perform  
25 the prescribed activities of daily living; or

26 (b) a severe cognitive impairment requiring substantial supervision, including verbal cueing, by  
27 another person to protect the insured from harming the insured or others for from threats to the insured's  
28 health or safety.

29 (3) An insured meets a condition of payment if, within the preceding 12-month period, a licensed  
30 health care practitioner has certified that the insured has met the requirements and the practitioner has

prescribed the qualified long-term care insurance services pursuant to a plan of care. Eligibility for the payment of benefits may not be more restrictive than requiring a deficiency in the ability to perform not more than three of the activities of daily living.

**NEW SECTION. Section 50. Codification instruction.** (1) [Sections ~~34, 35, 37, and 46~~ 33, 34, 36, AND 45] are intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [sections ~~34, 35, 37, and 46~~ 33, 34, 36, AND 45].

(2) [Sections ~~36, 40, 41, 43, and 45~~ 35, 39, 40, 42, AND 44] are intended to be codified as an integral part of Title 33, chapter 22, part 5, and the provisions of Title 33, chapter 22, part 5, apply to [sections ~~36, 40, 41, 43, and 45~~ 35, 39, 40, 42, AND 44].

(3) [Sections ~~38 and 39~~ 37 AND 38] are intended to be codified as an integral part of Title 33, chapter 22, part 2, and the provisions of Title 33, chapter 22, part 2, apply to [sections ~~38 and 39~~ 37 AND 38].

(4) [Section ~~42~~ 41] is intended to be codified as an integral part of Title 33, chapter 22, part 15, and the provisions of Title 33, chapter 22, part 15, apply to [section ~~42~~ 41].

(5) [Section ~~44~~ 43] is intended to be codified as an integral part of Title 33, chapter 31, and the provisions of Title 33, chapter 31, apply to [section ~~44~~ 43].

~~(6) [Sections 47 through 61] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 47 through 61].~~

~~(7) [Section 62] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 62].~~

~~(8) [Section 63] is intended to be codified as an integral part of Title 33, chapter 30, part 10, and the provisions of Title 33, chapter 30, part 10, apply to [section 63].~~

~~(9)(6) [Sections 64 through 67~~ 46 THROUGH 49] are intended to be codified as an integral part of Title 33, chapter 22, part 11, and the provisions of Title 33, chapter 22, part 11, apply to [sections ~~64 through 67~~ 46 THROUGH 49].

**NEW SECTION. SECTION 51. COORDINATION INSTRUCTION.** IF HOUSE BILL NO. 131 IS PASSED AND APPROVED AND IF IT AMENDS 33-22-1803(15), THEN 33-22-1803(15), AMENDING THE DEFINITION OF "HEALTH BENEFIT PLAN", MUST READ AS PROVIDED IN [SECTION 21 OF THIS ACT].

NEW SECTION. SECTION 52. APPLICABILITY. (1) EXCEPT AS PROVIDED IN SUBSECTION (2), [SECTIONS 1, 5 THROUGH 8, 17 THROUGH 40, AND 42 THROUGH 45] APPLY TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE OFFERED IN CONNECTION WITH GROUP HEALTH PLANS FOR GROUP HEALTH PLAN AND HEALTH INSURANCE COVERAGE CONTRACTS ISSUED OR RENEWED AFTER JUNE 30, 1997.

(2) [SECTION 36] APPLIES TO EVENTS OCCURRING AFTER JUNE 30, 1996.

**NEW SECTION. Section 53. Effective dates.** (1) Except as provided in ~~subsections~~ **SUBSECTION** **SUBSECTIONS (2) and (3)** **THROUGH (5)**, [this act] is effective October 1, 1997.

~~(2) [Sections 62 and 63] are effective January 1, 1988.~~

~~(3)(2)~~ [Sections 1, 5 through 9, ~~AND~~ 8, 17 through 46, and ~~61~~ ~~45~~ and this section 40, AND 42  
THROUGH 44] are effective July 1, 1997.

(3) [SECTION 9] IS EFFECTIVE JANUARY 1, 1998.

(4) [SECTION 41] IS EFFECTIVE SEPTEMBER 1, 1997.

(5) [SECTION 45 AND THIS SECTION] ARE EFFECTIVE ON PASSAGE AND APPROVAL.

**NEW SECTION.** **Section 54. Termination.** [Section 9(2) through (4)] terminates September 30, 2001.

-END-